

		FOR BHF USE			

LL1

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.

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

**I. IDPH License ID Number:** 0047415

**Facility Name:** Bloomington Rehab HCC

**Address:** 1925 South Main St Bloomington 61701  
 Number City Zip Code

**County:** McLean

**Telephone Number:** (309) 829-4348 **Fax #** (309) 827-4570

**HFS ID Number:** \_\_\_\_\_

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Mark Petersen</u>	
	(Title) <u>Chief Executive Officer</u>	
<b>Paid Preparer</b>	(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 Bloomington Rehab HCC

# 0047415 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	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		462	1,056	1,518	8
9	SNF/PED					9
10	ICF	12,333			12,333	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,333	462	1,056	13,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.65%

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 26 and days of care provided 965

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Bloomington Rehab HCC # 0047415 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
	<b>A. General Services</b>										
1	Dietary	115,556	12,558	1,915	130,029		130,029	3,688	133,717		1
2	Food Purchase		93,178		93,178		93,178	(1,500)	91,678		2
3	Housekeeping	77,222	19,885		97,107		97,107	71	97,178		3
4	Laundry	34,023	5,779		39,802		39,802		39,802		4
5	Heat and Other Utilities			51,692	51,692		51,692	252	51,944		5
6	Maintenance	44,693	6,287	25,068	76,048		76,048	12,239	88,287		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	271,494	137,687	78,675	487,856		487,856	14,750	502,606		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	743,100	74,718	751,280	1,569,098		1,569,098	3,462	1,572,560		10
10a	Therapy			189,263	189,263		189,263		189,263		10a
11	Activities	37,661	66	4,593	42,320		42,320	(947)	41,373		11
12	Social Services	12,700	15		12,715		12,715		12,715		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	793,461	74,799	969,136	1,837,396		1,837,396	2,515	1,839,911		16
	<b>C. General Administration</b>										
17	Administrative	67,721		145,400	213,121		213,121	(124,889)	88,232		17
18	Directors Fees										18
19	Professional Services			126,945	126,945		126,945	(11,923)	115,022		19
20	Dues, Fees, Subscriptions & Promotions			5,824	5,824		5,824	1,888	7,712		20
21	Clerical & General Office Expenses	41,110	3,121	14,994	59,225		59,225	26,018	85,243		21
22	Employee Benefits & Payroll Taxes			138,357	138,357		138,357	14,927	153,284		22
23	Inservice Training & Education			(308)	(308)		(308)	38	(270)		23
24	Travel and Seminar							12	12		24
25	Other Admin. Staff Transportation			10,064	10,064		10,064	2,642	12,706		25
26	Insurance-Prop.Liab.Malpractice			31,470	31,470		31,470	17,844	49,314		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	108,831	3,121	472,746	584,698		584,698	(73,443)	511,255		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,173,786	215,607	1,520,557	2,909,950		2,909,950	(56,178)	2,853,772		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.

Facility Name &amp; ID Number

Bloomington Rehab HCC

#0047415

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			6,685	6,685		6,685	50,972	57,657			30
31	Amortization of Pre-Op. & Org.							7,142	7,142			31
32	Interest			909	909		909	63,143	64,052			32
33	Real Estate Taxes							26,439	26,439			33
34	Rent-Facility & Grounds			190,304	190,304		190,304	(190,304)				34
35	Rent-Equipment & Vehicles			50,671	50,671		50,671	7,415	58,086			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			248,569	248,569		248,569	(35,193)	213,376			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,550		16,550		16,550		16,550			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,278	117,278		117,278		117,278			42
43	Other (specify):*	34,644		59,919	94,563		94,563	(94,563)				43
44	<b>TOTAL Special Cost Centers</b>	34,644	16,550	177,197	228,391		228,391	(94,563)	133,828			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,208,430	232,157	1,946,323	3,386,910		3,386,910	(185,934)	3,200,976			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Bloomington Rehab HCC**

# **0047415**

Report Period Beginning:

**1/1/2020**

Ending:

**12/31/2020**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,500)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,008)	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	(3,122)	30		9
10	Interest and Other Investment Income	(152)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28,966)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(110,535)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,680)	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	(44,553)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (212,681)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	26,747	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 26,747		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (185,934)		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	

**Bloomington Rehab HCC**

ID# 0047415

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,343)	43	1
2	X-Rays-Part A	422	43	2
3	Special Events	821	43	3
4	Offset Miscellaneous Office Supplies Revenue	(38)	21	4
5	Offset Transportation Trans. Revenue	(947)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(1,824)	10	6
7	Disallowed Marketing Salaries	(34,644)	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	<b>Total</b>	(44,553)		49

Facility Name & ID Number

Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,688	\$ 3,688	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%	71	71	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	252	252	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,215	2,215	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,456	3,456	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	145,400	Petersen Health Care Management, Inc.	100.00%	20,511	(124,889)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	12,115	12,115	12
13	V							13
14	Total		\$ 145,400			\$ 42,308	\$ * (103,092)	14

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

Facility Name & ID Number Bloomington Rehab HCC

# 0047415

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 1,888	\$ 1,888
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	22,868	22,868
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	6,278	6,278
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	38	38
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	12	12
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,642	2,642
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	403	403
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	3,733	3,733
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0	
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	182	182
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	145	145
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,339	1,339
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$			\$ 39,528	\$ * 39,528

\* 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 Care Management, Inc.	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%			16
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%			17
18	V	4 Laundry		Petersen Health Care Management, Inc.	100.00%			18
19	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%			19
20	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	1,830	1,830	22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%			23
24	V	17 Administrative		Petersen Health Care Management, Inc.	100.00%			24
25	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	79,792	79,792	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%			26
27	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%			27
28	V	22 Employee Benefits & Payroll		Petersen Health Care Management, Inc.	100.00%	8,649	8,649	28
29	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%			32
33	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%			33
34	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%			34
35	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	6,162	6,162	35
36	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Care Management, Inc.	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	6,076	6,076	38
39	Total		\$			\$ 102,509	\$ * 102,509	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	\$	Bloomington Land, LLC	100.00%	\$ 10,024	\$ 10,024
16	V	19 Professional Services	\$	Bloomington Land, LLC	100.00%	6,705	6,705
17	V	21 Equipment		Bloomington Land, LLC	100.00%	3,188	3,188
18	V	26 Insurance-Property		Bloomington Land, LLC	100.00%	6,739	6,739
19	V	26 Insurance-Mortgage Insurance		Bloomington Land, LLC	100.00%	10,702	10,702
20	V	30 Depreciation		Bloomington Land, LLC	100.00%	50,361	50,361
21	V	31 Amortization		Bloomington Land, LLC	100.00%	7,142	7,142
22	V	32 Interest	1,260	Bloomington Land, LLC	100.00%	63,394	62,134
23	V	33 Real Estate Taxes		Bloomington Land, LLC	100.00%	26,294	26,294
24	V	34 Rent-Income and Grounds	195,487	Bloomington Land, LLC	100.00%		(195,487)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 196,747			\$ 184,549	\$ * (12,198)

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

Facility Name &amp; ID Number

Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name &amp; ID Number

Bloomington Rehab HCC

# 0047415

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 &amp; ID Number

Bloomington Rehab HCC

# 0047415

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

Bloomington Rehab HCC

# 0047415

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 Bloomington Rehab HCC # 0047415 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 Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Care Management, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	13,851	\$ 3,688	1
2	2	Food	Resident Days	1,282,791	75	0	0	13,851	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	13,851	71	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	13,851	252	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	13,851	2,215	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	13,851	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	13,851	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	13,851	3,456	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	13,851	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	13,851	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	13,851	20,511	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	13,851	12,115	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	13,851	1,888	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	13,851	22,868	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	13,851	6,278	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	13,851	38	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	13,851	12	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	13,851	2,642	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	13,851	403	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	13,851	3,733	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	13,851	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	13,851	182	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	13,851	145	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	13,851	1,339	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 81,836	25



Facility Name & ID Number Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Operations, LLC  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309)691-8113  
 Fax Number (309)691-8622

1	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	163,986	9	\$	\$	13,851	\$	1
2	2	Food	Resident Days	163,986	9			13,851		2
3	3	Housekeeping	Resident Days	163,986	9			13,851		3
4	4	Laundry	Resident Days	163,986	9			13,851		4
5	5	Utilities	Resident Days	163,986	9			13,851		5
6	6	Maintenance	Resident Days	163,986	9			13,851		6
7	7	Mgmt. Allocation of Benefits	Resident Days	163,986	9			13,851		7
8	10	Nursing and Medical Records	Resident Days	163,986	9	21,660		13,851	1,830	8
9	15	Mgmt. Allocation of Benefits	Resident Days	163,986	9			13,851		9
10	17	Administrative	Resident Days	163,986	9			13,851		10
11	19	Professional Services	Resident Days	163,986	9	944,677		13,851	79,792	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	163,986	9			13,851		12
13	21	Clerical and General Office	Resident Days	163,986	9			13,851		13
14	22	Employee Benefits & Payroll	Resident Days	163,986	9	102,400		13,851	8,649	14
15	23	Inservice Training & Education	Resident Days	163,986	9			13,851		15
16	24	Travel and Seminar	Resident Days	163,986	9			13,851		16
17	25	Other Admin. Staff Transport.	Resident Days	163,986	9			13,851		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	163,986	9			13,851		18
19	30	Depreciation	Resident Days	163,986	9			13,851		19
20	31	Amortization	Resident Days	163,986	9			13,851		20
21	32	Interest	Resident Days	163,986	9	72,956		13,851	6,162	21
22	33	Real Estate Taxes	Resident Days	163,986	9			13,851		22
23	34	Rent-Facility and Grounds	Resident Days	163,986	9			13,851		23
24	35	Rent-Equipment & Vehicles	Resident Days	163,986	9	71,940		13,851	6,076	24
25	TOTALS					\$ 1,213,633	\$		\$ 102,509	25

Facility Name & ID Number

Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Capital Finance Group		X	Mortgage	Varies	10/1/2014	\$ 2,019,400	\$ 1,613,102	12/31/2024	Varies	\$ 58,211	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				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 2,067,883	\$ 1,657,143			\$ 59,120	9				
<b>B. Non-Facility Related*</b>																
10							Interest Income Offset				(1,412)	10				
11							Home Office Allocation-PHCM				182	11				
12							Home Office Allocation-PHO				6,162	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 4,932	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 2,067,883	\$ 1,657,143			\$ 64,052	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 10,702 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.)

Facility Name & ID Number **Bloomington Rehab HCC**# **0047415**

Report Period Beginning:

**1/1/2020**

Ending:

**12/31/2020****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2019 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>		\$	<b>25,740</b>	<b>1</b>
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.)		\$	<b>25,634</b>			<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(106)</b>			<b>3</b>
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>26,400</b>			<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$				<b>5</b>
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.						
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>					<b>Home Office Allocation</b>	<b>145</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>26,439</b>			<b>6</b>
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2015	<u>22,661</u>	<b>8</b>			
	2016	<u>23,825</u>	<b>9</b>			
	2017	<u>23,907</u>	<b>10</b>			
	2018	<u>24,992</u>	<b>11</b>			
	2019	<u>25,634</u>	<b>12</b>			
<b>Accrual based on prior year tax bill.</b>						
				<b>FOR BHF USE ONLY</b>		
				<b>13</b>	FROM R. E. TAX STATEMENT FOR 2019	<b>13</b>
				<b>14</b>	PLUS APPEAL COST FROM LINE 5	<b>14</b>
				<b>15</b>	LESS REFUND FROM LINE 6	<b>15</b>
				<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**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 Bloomington Rehab HCC COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047415

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-16-128-012</u>	<u>Long-Term Care Facility</u>	\$ <u>25,633.60</u>	\$ <u>25,633.60</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>25,633.60</u></u>	\$ <u><u>25,633.60</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 15,386 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: 157,125 2. Number of Years Over Which it is Being Amortized: 20  
3. Current Period Amortization: 7,142 4. Dates Incurred: 2013-2014

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	<u>Facility</u>	<u>66,211</u>	<u>2005</u>	<u>\$ 87,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>66,211</b>		<b>\$ 87,500</b>	<b>3</b>

**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	78	2005	1972	\$ 528,930	\$	30	\$ 20,800	\$ 20,800	\$ 322,400	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Land Improvements	2005		13,000		15	867	867	12,571	9
10	Backflow	2008		9,779		25	392	392	4,508	10
11	Sprinkler Installation	2009		13,662		15	911	911	9,565	11
12	Water Service Line Repair	2009		5,990		7			5,990	12
13	Parking Lot Repair	2011		38,631		15	2,576	2,576	20,176	13
14	Sprinkler Work	2011		16,800		15	1,120	1,120	9,520	14
15	Water Leak Repair	2012		9,216		7	662	662	9,216	15
16	Roof Replacement	2013		60,115		25	2,405	2,405	15,632	16
17	Sprinkler Pipe Repair	2015		3,100		7	444	444	1,998	17
18	Attic Piping Repair	2015		6,044		7	864	864	3,888	18
19	Dry Sprinkler Head Repair	2015		3,769		7	538	538	2,421	19
20	Drainage of Wet Land on Property	2017		7,500		7	1,071	1,071	2,728	20
21	Patio and Walk Replacement	2017		3,565		15	238	238	595	21
22	Water Pipe Replacement	2018		42,389		15	2,826	2,826	4,239	22
23	Sprinkler Pipe Repair	2018		5,400		7	772	772	1,158	23
24	Furniture and Air Conditioner	2018		7,574		15	504	504	756	24
25	Water Heater Replacement	2019		3,721		7	266	266	266	25
26	Drywall Repair in Kitchen, Break Room, Living Room	2019		2,950		7	211	211	211	26
27	Water Heater Replacement	2020		2,852		7	204	204	204	27
28										28
29										29
30										30
31	Land Improvements Booked				1,519			(1,519)		31
32	Building Booked				20,826			(20,826)		32
33	Building Improvement Booked				17,180			(17,180)		33
34										34
35	2020-Home Office Allocation-Building Improvements			7,003			168	168		35
36	2020-Home Office Allocation-Land Improvements			702			44			36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ <b>792,692</b>	\$ <b>39,525</b>	\$ <b>37,883</b>	\$ <b>(1,686)</b>	\$ <b>428,042</b>	<b>70</b>

\*\*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	\$ 94,872	\$ 11,865	\$ 11,405	\$ (460)	5-10 yrs.	\$ 58,612	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	123,526					123,526	73
74				3,521	3,521			74
75	TOTALS	\$ 218,398	\$ 11,865	\$ 14,926	\$ 3,061		\$ 182,138	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 Pro	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 Reference	2 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)	\$ 1,147,073	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 57,046	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,657	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 611	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 615,028	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.



Facility Name & ID Number Bloomington Rehab HCC

# 0047415

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

**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	<b>TOTAL</b>				\$			7

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	\$ _____

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: \$ 58,086 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	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**Bloomington Rehab HCC**

**0047415**

**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	\$	45,390
Dishwasher		956
Copier		4,325
Home Office Allocation		7,415
		<u>58,086</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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	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	\$	5,004	\$ 75,067	\$	5,004	\$ 75,067	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,213	33,198		2,213	33,198	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,400	80,998		5,400	80,998	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				16,550		16,550	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			\$	12,617	\$ 189,263	\$ 16,550	12,617	\$ 205,813	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.

Facility Name & ID Number **Bloomington Rehab HCC**# **0047415**Report Period Beginning: **1/1/2020**Ending: **12/31/2020****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2020**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 788,793	\$ 788,793	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>67,251</u> )	1,894,221	1,894,221	3
4	Supply Inventory (priced at <u>Cost</u> )	8,321	8,321	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,734	27,623	6
7	Other Prepaid Expenses		20,015	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,707,069	\$ 2,738,973	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		429,847	12
13	Land		87,500	13
14	Buildings, at Historical Cost		535,933	14
15	Leasehold Improvements, at Historical Cost	16,415	256,759	15
16	Equipment, at Historical Cost	48,483	266,881	16
17	Accumulated Depreciation (book methods)	(14,715)	(615,028)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		157,125	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(44,638)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	41,049	70,779	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 91,232	\$ 1,145,158	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,798,301	\$ 3,884,131	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 747,647	\$ 757,780	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,553	46,553	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,400	32
33	Accrued Interest Payable		5,175	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	119,364	119,364	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 913,564	\$ 955,272	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	44,041	44,041	39
40	Mortgage Payable		1,613,102	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44	<u>Loan Payable-MCAD Adv. Payment</u>	450,000	450,000	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 494,041	\$ 2,107,143	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,407,605	\$ 3,062,415	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,390,696	\$ 821,716	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,798,301	\$ 3,884,131	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>271,751</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Reports Were Filed</b>	<b>106,657</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>378,408</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,012,288</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,012,288</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,390,696</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Bloomington Rehab HCC

# 0047415

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.**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,818,687	1
2	Discounts and Allowances for all Levels	(212,453)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,606,234	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,761	6
7	Oxygen	659	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 250,420	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,500	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,523	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,538	20
21	Other Medical Services	9,260	21
22	Laundry	72	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 50,893	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	152	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 152	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	947	28
28a	<u>Miscellaneous and Illinois Cares Revenue</u>	1,490,552	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,491,499	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,399,198	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	487,856	31
32	Health Care	1,837,396	32
33	General Administration	584,698	33
<b>B. Capital Expense</b>			
34	Ownership	248,569	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	111,113	35
36	Provider Participation Fee	117,278	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,386,910	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,012,288	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,012,288	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,006,172	44
45	Private Pay - Net Inpatient Revenue	113,595	45
46	Medicare - Net Inpatient Revenue	433,588	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	52,879	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,606,234	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.

Facility Name & ID Number Bloomington Rehab HCC

# 0047415

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**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	1,796	1,964	\$ 82,856	\$ 42.19	1
2	Assistant Director of Nursing	285	285	9,647	33.85	2
3	Registered Nurses	7,710	7,865	256,445	32.61	3
4	Licensed Practical Nurses	3,848	3,961	102,755	25.94	4
5	CNAs & Orderlies	14,652	14,897	241,109	16.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,593	1,651	22,276	13.49	9
10	Activity Assistants	440	440	5,237	11.90	10
11	Social Service Workers	1,074	1,074	12,700	11.82	11
12	Dietician					12
13	Food Service Supervisor	2,067	2,099	31,198	14.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,476	6,630	84,358	12.72	15
16	Dishwashers					16
17	Maintenance Workers	1,789	1,902	44,693	23.50	17
18	Housekeepers	6,967	7,111	77,222	10.86	18
19	Laundry	2,519	2,809	34,023	12.11	19
20	Administrator	2,132	2,205	60,000	27.21	20
21	Assistant Administrator	292	292	7,721	26.44	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	41,110	19.76	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	4,105	4,105	95,080	23.16	33
34	TOTAL (lines 1 - 33)	59,825	61,370	\$ 1,208,430 *	\$ 19.69	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	40	\$ 1,915	L1, C3	35
36	Medical Director	Monthly	24,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,949	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	16	871	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Telehealth</u>	3	175	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	59	\$ 30,910		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	421	\$ 26,088	L10,C3	50
51	Licensed Practical Nurses	7,477	325,003	L10,C3	51
52	Certified Nurse Assistants/Aides	10,676	395,194	L10,C3	52
53	TOTAL (lines 50 - 52)	18,574	\$ 746,285		53



**Bloomington Rehab HCC**

**0047415**

**Period Beginning 1/1/2020**

**Period End 12/31/2020**

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
<b>Care Plan Coordinator</b>	1,088	1,088	50,288	46.22
<b>Transportation</b>	937	937	10,148	10.83
<b>Marketing</b>	2,080	2,080	34,644	16.66
<b>TOTAL</b>	<u>4,105</u>	<u>4,105</u>	<u>95,080</u>	

**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	
Janice Kindred	Administrator	0	\$ 11,231	Workers' Compensation Insurance	\$ 18,887	IDPH License Fee	\$ 1,990	
Kacinda Helfers	Administrator	0	40,221	Unemployment Compensation Insurance	14,450	Advertising: Employee Recruitment	868	
Megan Purdy	Administrator	0	16,269	FICA Taxes	86,565	Health Care Worker Background Check (Indicate # of checks performed <u>19</u> )		
				Employee Health Insurance	3,394	Patient Background Checks	84	
				Employee Meals		Miscellaneous Licenses & Permits	1,003	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions		
				Employee Relations	2,191	Home Office Allocation	1,888	
				Home Office Allocation	14,927			
				Employee Retirement	870			
				Administrator Benefits	12,000			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,721					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 145,400					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 145,400					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Steven Silvey	Legal Settlement		\$ 110,535				Out-of-State Travel	\$
Comcast	Computer Services		505					
Allscripts	Data Services		1,816				In-State Travel	
Sorling Northrup	Legal Fees		6,660					
Ability Network	Computer Services		7,386				Seminar Expense	
Ameritas Life Insurance	Legal Fees		43	N/A			Home Office Allocation	12
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 126,945	TOTAL		\$	TOTAL	\$ 12

\* Attach copy of IMRF notifications

\*\*See instructions.

**Bloomington Rehab HCC**

0047415

Period Beginning

1/1/2020

Period End

12/31/2020

## Schedule 21A

**XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		126,945
Non-Allowable Legal Settlement		(110,535)
<b>Home Office Allocation</b>		
Baker Tilly Virchow Krause LLP	Legal	318
Duane Morris	Legal	23,012
Lexis Nexis	Legal	6
Livingston, Barger, Brant, Schroeder	Legal	9,626
Miller, Hall, Triggs	Legal	37
Miscellaneous	Legal	14
SB2	Legal	637
SmithAmundsen LLC	Legal	1,517
Sorling Northrup	Legal	364
Capital Finance Group	Legal	3,149
Illinois Secretary of State	Legal	102
McGuire Woods	Legal	4,223
CliftonLarsonAllen	Accounting	847
Ginoli & Co.	Accounting	9,501
Ability Network	Computer Services	2,174
Allscripts	Computer Services	343
AOD Matrix Care	Computer Services	3,818
AT&T	Computer Services	4
ATS	Computer Services	208
CCH	Computer Services	12
Charter Communications	Computer Services	19
Citrix Systems	Computer Services	65
Comcast	Computer Services	22
ITSavvy	Computer Services	100
Kemper Technology	Computer Services	496
Miscellaneous	Computer Services	96
Pearl Technology	Computer Services	90
Stratus Networks	Computer Services	394
TR Professional	Computer Services	8
Creative Health Capital	Other Prof Fees	3,416
Mohr and Kerr	Other Prof Fees	6,222
Planning and Zoning Resource Company	Other Prof Fees	874
David Budde	Other Prof Fees	9
DJ Howard and Associates	Other Prof Fees	819
Getzler Henrich & Associates	Other Prof Fees	881
LRI Consulting Services	Other Prof Fees	890
McQuellon Consulting	Other Prof Fees	548
Miscellaneous	Other Prof Fees	82
Optimizer	Other Prof Fees	35
Registered Agent Solutions	Other Prof Fees	20
RSM McGladrey	Other Prof Fees	216
SB2	Other Prof Fees	276
Sedgwick CMS	Other Prof Fees	23,071
Tarver Program Consultants	Other Prof Fees	51
Total (agree to Schedule V, line 19, column 8)		<u>115,022</u>

**Bloomington Rehab HCC**

**0047415**

**Period Beginning**      1/1/2020

**Period End**            12/31/2020

**Schedule 21B**

**25. Administrative and Staff Transportation**

Gas	\$	1,732
Auto Repairs		1,707
Mileage-Travel		6,625
Home Office Allocation		<u>2,642</u>
		<u><u>12,706</u></u>

Facility Name & ID Number Bloomington Rehab HCC# 0047415Report Period Beginning: 1/1/2020Ending: 12/31/2020**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,143 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. \$ 117,278  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,500
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 947  
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. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees.