

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0053157</u></p> <p>Facility Name: <u>Enfield Rehab Health Care Ct</u></p> <p>Address: <u>408 North Wilson St</u> <u>Enfield</u> <u>62835</u> Number City Zip Code</p> <p>County: <u>White</u></p> <p>Telephone Number: <u>(618) 963-2331</u> Fax # <u>(618) 963-2083</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/01/2005</u></p> <p>Type of Ownership:</p> <table border="0" style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<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	IRS Exemption Code _____	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:15%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																												

Facility Name & ID Number Enfield Rehab Health Care Ct

0053157 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	23	Skilled (SNF)	23	8,395	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	47	TOTALS	47	17,155	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		833	292	1,125	8
9	SNF/PED					9
10	ICF	6,110			6,110	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,110	833	292	7,235	14

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

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 23 and days of care provided 292

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 Enfield Rehab Health Care Ct # 0053157 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	102,816	9,336		112,152		112,152	1,926	114,078		1
2	Food Purchase		55,431		55,431		55,431	(2,079)	53,352		2
3	Housekeeping	59,781	16,964		76,745		76,745	37	76,782		3
4	Laundry		2,288		2,288		2,288		2,288		4
5	Heat and Other Utilities			32,136	32,136		32,136	132	32,268		5
6	Maintenance	12,814	3,286	14,988	31,088		31,088	1,157	32,245		6
7	Other (specify):*										7
8	TOTAL General Services	175,411	87,305	47,124	309,840		309,840	1,173	311,013		8
	B. Health Care and Programs										
9	Medical Director			19,350	19,350		19,350		19,350		9
10	Nursing and Medical Records	466,263	37,721	3,403	507,387		507,387	291	507,678		10
10a	Therapy			52,197	52,197		52,197		52,197		10a
11	Activities	21,837	77		21,914		21,914	241	22,155		11
12	Social Services	25,566			25,566		25,566		25,566		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	513,666	37,798	74,950	626,414		626,414	532	626,946		16
	C. General Administration										
17	Administrative	62,004		57,900	119,904		119,904	(47,186)	72,718		17
18	Directors Fees										18
19	Professional Services			6,247	6,247		6,247	6,757	13,004		19
20	Dues, Fees, Subscriptions & Promotions			5,329	5,329		5,329	986	6,315		20
21	Clerical & General Office Expenses	12,951	1,259	11,256	25,466		25,466	11,935	37,401		21
22	Employee Benefits & Payroll Taxes			91,676	91,676		91,676	3,279	94,955		22
23	Inservice Training & Education							20	20		23
24	Travel and Seminar			(69)	(69)		(69)	6	(63)		24
25	Other Admin. Staff Transportation			2,469	2,469		2,469	1,380	3,849		25
26	Insurance-Prop.Liab.Malpractice			26,812	26,812		26,812	210	27,022		26
27	Other (specify):*										27
28	TOTAL General Administration	74,955	1,259	201,620	277,834		277,834	(22,613)	255,221		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	764,032	126,362	323,694	1,214,088		1,214,088	(20,908)	1,193,180		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 & ID Number Enfield Rehab Health Care Ct

#0053157

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			26,933	26,933		26,933	2,416	29,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							213	213			32
33	Real Estate Taxes			8,016	8,016		8,016	76	8,092			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,818	24,818		24,818	699	25,517			35
36	Other (specify):*											36
37	TOTAL Ownership			59,767	59,767		59,767	3,404	63,171			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,404		4,404		4,404		4,404			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,806	67,806		67,806		67,806			42
43	Other (specify):*			30,222	30,222		30,222	(30,222)				43
44	TOTAL Special Cost Centers		4,404	98,028	102,432		102,432	(30,222)	72,210			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	764,032	130,766	481,489	1,376,287		1,376,287	(47,726)	1,328,561			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 Enfield Rehab Health Care Ct

0053157

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,079)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,645)	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	466	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(138)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,275)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,000)	43		24
25	Fund Raising, Advertising and Promotional	(200)	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	(2,247)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,120)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(14,772)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (14,772)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (47,892)		37

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

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

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

Enfield Rehab Health Care Ct

ID# 0053157

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (772)	43	1
2	X-Rays-Part A	(215)	43	2
3	Offset Transportation Revenue	241	11	3
4	Offset Miscellaneous Office Supplies Revenue	(10)	21	4
5	Disallowed Special Events	23	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(1,514)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,247)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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%	\$ 1,921	\$ 1,921	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%	37	37	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	131	131	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,153	1,153	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%	1,800	1,800	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	57,900	Petersen Health Care Management, Inc.	100.00%	10,681	(47,219)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	6,309	6,309	12
13	V							13
14	Total		\$ 57,900			\$ 22,032	\$ * (35,868)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 983	\$	983	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	11,909		11,909	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	3,269		3,269	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	20		20	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	6		6	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,376		1,376	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	210		210	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	1,944		1,944	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0		0	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	95		95	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	76		76	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	697		697	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 20,585	\$ *	20,585	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Wellness, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Wellness, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Wellness, LLC	100.00%			17
18	V	4 Laundry		Petersen Health Wellness, LLC	100.00%			18
19	V	5 Utilities		Petersen Health Wellness, LLC	100.00%			19
20	V	6 Maintenance		Petersen Health Wellness, LLC	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%			22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%			23
24	V	17 Administrative		Petersen Health Wellness, LLC	100.00%			24
25	V	19 Professional Services		Petersen Health Wellness, LLC	100.00%	400	400	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%			26
27	V	21 Clerical and General Office		Petersen Health Wellness, LLC	100.00%			27
28	V	22 Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%			28
29	V	23 Inservice Training & Education		Petersen Health Wellness, LLC	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Wellness, LLC	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%			32
33	V	30 Depreciation		Petersen Health Wellness, LLC	100.00%			33
34	V	31 Amortization		Petersen Health Wellness, LLC	100.00%			34
35	V	32 Interest		Petersen Health Wellness, LLC	100.00%	111	111	35
36	V	33 Real Estate Taxes		Petersen Health Wellness, LLC	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%			38
39	Total		\$			\$ 511	\$ * 511	39

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

Facility Name & ID Number

Enfield Rehab Health Care Ct

0053157

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 & ID Number

Enfield Rehab Health Care Ct

0053157

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Enfield Rehab Health Care Ct

0053157

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

Enfield Rehab Health Care Ct

0053157

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

Enfield Rehab Health Care Ct

0053157

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 Enfield Rehab Health Care Ct

0053157

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	1,286,694	75	\$ 341,556	\$ 398,718	7,235	\$ 1,921	1
2	2	Food	Resident Days	1,286,694	75	0	0	7,235	0	2
3	3	Housekeeping	Resident Days	1,286,694	75	6,605	3,056	7,235	37	3
4	5	Utilities	Resident Days	1,286,694	75	23,319	0	7,235	131	4
5	6	Maintenance	Resident Days	1,286,694	75	205,135	187,746	7,235	1,153	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,286,694	75	0	0	7,235	0	6
7	9	Medical Director	Resident Days	1,286,694	75	0	0	7,235	0	7
8	10	Nursing and Medical Records	Resident Days	1,286,694	75	320,054	736,064	7,235	1,800	8
9	10A	Therapy	Resident Days	1,286,694	75	0	0	7,235	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,286,694	75	0	0	7,235	0	10
11	17	Administrative	Resident Days	1,286,694	75	1,899,564	7,673,667	7,235	10,681	11
12	19	Professional Services	Resident Days	1,286,694	75	1,122,027	0	7,235	6,309	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,286,694	75	174,864	0	7,235	983	13
14	21	Clerical and General Office	Resident Days	1,286,694	75	2,117,879	2,195,755	7,235	11,909	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,286,694	75	581,392	0	7,235	3,269	15
16	23	Inservice Training & Education	Resident Days	1,286,694	75	3,515	0	7,235	20	16
17	24	Travel and Seminar	Resident Days	1,286,694	75	1,093	0	7,235	6	17
18	25	Other Admin. Staff Transport.	Resident Days	1,286,694	75	244,707	0	7,235	1,376	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,286,694	75	37,296	0	7,235	210	19
20	30	Depreciation	Resident Days	1,286,694	75	345,756	0	7,235	1,944	20
21	31	Amortization	Resident Days	1,286,694	75	0	0	7,235	0	21
22	32	Interest	Resident Days	1,286,694	75	16,848	0	7,235	95	22
23	33	Real Estate Taxes	Resident Days	1,286,694	75	13,448	0	7,235	76	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,286,694	75	124,022	0	7,235	697	24
25	TOTALS					\$ 7,579,080	\$ 11,195,006		\$ 42,617	25

Facility Name & ID Number Enfield Rehab Health Care Ct

0053157

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 Wellness, 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	70,065	8	\$	\$	7,235	\$	1
2	2	Food	Resident Days	70,065	8			7,235		2
3	3	Housekeeping	Resident Days	70,065	8			7,235		3
4	4	Laundry	Resident Days	70,065	8			7,235		4
5	5	Utilities	Resident Days	70,065	8			7,235		5
6	6	Maintenance	Resident Days	70,065	8			7,235		6
7	7	Mgmt. Allocation of Benefits	Resident Days	70,065	8			7,235		7
8	10	Nursing and Medical Records	Resident Days	70,065	8			7,235		8
9	15	Mgmt. Allocation of Benefits	Resident Days	70,065	8			7,235		9
10	17	Administrative	Resident Days	70,065	8			7,235		10
11	19	Professional Services	Resident Days	70,065	8	3,870		7,235	400	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	70,065	8			7,235		12
13	21	Clerical and General Office	Resident Days	70,065	8			7,235		13
14	22	Employee Benefits & Payroll	Resident Days	70,065	8			7,235		14
15	23	Inservice Training & Education	Resident Days	70,065	8			7,235		15
16	24	Travel and Seminar	Resident Days	70,065	8			7,235		16
17	25	Other Admin. Staff Transport.	Resident Days	70,065	8			7,235		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	70,065	8			7,235		18
19	30	Depreciation	Resident Days	70,065	8			7,235		19
20	31	Amortization	Resident Days	70,065	8			7,235		20
21	32	Interest	Resident Days	70,065	8	1,079		7,235	111	21
22	33	Real Estate Taxes	Resident Days	70,065	8			7,235		22
23	34	Rent-Facility and Grounds	Resident Days	70,065	8			7,235		23
24	35	Rent-Equipment & Vehicles	Resident Days	70,065	8			7,235		24
25	TOTALS					\$ 4,949	\$		\$ 511	25

Facility Name & ID Number

Enfield Rehab Health Care Ct

0053157

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		7	8	9	10						
		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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$	9						
B. Non-Facility Related*																		
10									Interest Income Offset			(2)	10					
11									Home Office Allocation-PHCM			95	11					
12									Home Office Allocation-PHW			120	12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	213	14					
15	TOTALS (line 9+line14)						\$	\$			\$	213	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.	\$	15,776	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	7,760	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(8,016)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	16,032	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation		76	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	8,092	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		2015	<u>7,363</u>	8
		2016	<u>7,436</u>	9
		2017	<u>7,924</u>	10
		2018	<u>7,787</u>	11
		2019	<u>7,760</u>	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Enfield Rehabilitation & Health Care Center COUNTY White

FACILITY IDPH LICENSE NUMBER 0053157

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>12-09-302-001</u>	<u>Long-Term Care Facility</u>	\$ <u>7,760.08</u>	\$ <u>7,760.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>7,760.08</u></u>	\$ <u><u>7,760.08</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 Enfield Rehab Health Care Ct

0053157 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,476 B. General Construction Type: Exterior Brick & Concrete Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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 [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 75,359, 2005, \$ 15,750, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 75,359, (blank), \$ 15,750, 3.

Facility Name & ID Number Enfield Rehab Health Care Ct

0053157

Report Period Beginning:

1/1/2020

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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	49	2005	1972	\$ 290,250	\$	25	\$ 11,610	\$ 11,610	\$ 182,217	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Door Alarm		2007	1,636		15	109	109	1,472	9
10	Air Compressor		2007	1,302		15	87	87	1,174	10
11	New Roof		2007	29,725		20	1,486	1,486	20,061	11
12	Awning		2008	2,569		20	128	128	1,600	12
13	Sprinkler System		2011	2,990		7			2,990	13
14	Sidewalk and Pavement Replacement		2013	35,360		25	1,414	1,414	10,605	14
15	Ceramic and vinyl tile installment-Main Hallways		2014	20,489		15	1,366	1,366	8,879	15
16	Water Heater		2014	14,671		7	2,096	2,096	13,624	16
17	Door Replacement		2016	32,581		15	2,172	2,172	9,774	17
18	Dry Valve Replacement		2016	9,790		7	1,398	1,398	6,291	18
19	Sprinkler Repair		2017	7,113		7	1,016	1,016	3,556	19
20	Water Pipe Repair		2019	6,550		7	936	936	1,404	20
21	Roof Repair		2019	7,213		7	1,030	1,030	1,545	21
22	Sprinkler Repair		2020	3,051		7	218	218	218	22
23										23
24										24
25										25
26										26
27										27
28										28
29	Land Improvements Booked				500			(500)		29
30	Building Booked				11,253			(11,253)		30
31	Building Improvement Booked				13,478			(13,478)		31
32										32
33	2020-Home Office Allocation-Building Improvements			3,658			88	88		33
34	2020-Home Office Allocation-Land Improvements			367			23	23		34
35										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

Facility Name & ID Number Enfield Rehab Health Care Ct

0053157

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 469,315	\$ 25,231		\$ 25,177	\$ (54)	\$ 265,410	70

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

Facility Name & ID Number Enfield Rehab Health Care Ct

0053157

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	\$ 19,771	\$ 1,702	\$ 2,333	\$ 631	5-10 yrs.	\$ 13,904	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	76,131					76,131	73
74	Home Office Allocation			1,839	1,839			74
75	TOTALS	\$ 95,902	\$ 1,702	\$ 4,172	\$ 2,470		\$ 90,035	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 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)	\$ 580,967	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,933	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,349	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,416	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 355,445	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 Enfield Rehab Health Care Ct

0053157

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	TOTAL				\$			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: \$ 25,517 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

**Enfield Rehab Health Care Ct
0053157**

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	\$ 20,081
Dishwasher	701
Copier	4,036
Home Office Allocation	699
	<u>25,517</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$	1,628	\$ 24,426	\$	1,628	\$ 24,426	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		370	5,548		370	5,548	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,482	22,223		1,482	22,223	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				4,404		4,404	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			\$	3,480	\$ 52,197	\$ 4,404	3,480	\$ 56,601	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.

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (2,106)	\$ (2,106)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 13,977)	260,811	260,811	3
4	Supply Inventory (priced at Cost)	5,203	5,203	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,225	15,225	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 279,133	\$ 279,133	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	293,908	14
15	Leasehold Improvements, at Historical Cost	175,040	175,407	15
16	Equipment, at Historical Cost	95,902	95,902	16
17	Accumulated Depreciation (book methods)	(351,786)	(355,445)	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)	\$ 225,156	\$ 225,522	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 504,289	\$ 504,655	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 243,412	\$ 243,412	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,472	32,472	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,032	16,032	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	40,045	40,045	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 331,961	\$ 331,961	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	<u>Loan Payable-MCAD Adv. Payment</u>	54,012	54,012	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 54,012	\$ 54,012	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 385,973	\$ 385,973	46
47	TOTAL EQUITY(page 18, line 24)	\$ 118,316	\$ 118,682	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 504,289	\$ 504,655	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (143,668)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	433,516	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 289,848	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(171,532)	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)	\$ (171,532)	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)	\$ 118,316	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,267,932	1
2	Discounts and Allowances for all Levels	(205,007)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,062,925	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	80,350	6
7	Oxygen	9	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 80,359	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,079	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,964	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,947	20
21	Other Medical Services	2,233	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,223	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	(241)	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	47,487	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 47,246	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,204,755	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	309,840	31
32	Health Care	626,414	32
33	General Administration	277,834	33
B. Capital Expense			
34	Ownership	59,767	34
C. Ancillary Expense			
35	Special Cost Centers	34,626	35
36	Provider Participation Fee	67,806	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,376,287	40
41	Income before Income Taxes (line 30 minus line 40)**	(171,532)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (171,532)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 843,393	44
45	Private Pay - Net Inpatient Revenue	150,565	45
46	Medicare - Net Inpatient Revenue	68,967	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,062,925	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 Enfield Rehab Health Care Ct

0053157

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	1,319	1,360	\$ 35,857	\$ 26.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,866	1,880	46,989	24.99	3
4	Licensed Practical Nurses	6,287	6,359	126,360	19.87	4
5	CNAs & Orderlies	14,073	14,317	204,630	14.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,696	1,742	21,525	12.36	9
10	Activity Assistants					10
11	Social Service Workers	1,811	1,811	25,566	14.12	11
12	Dietician					12
13	Food Service Supervisor	1,778	1,947	30,117	15.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,358	7,720	72,699	9.42	15
16	Dishwashers					16
17	Maintenance Workers	929	937	12,814	13.68	17
18	Housekeepers	4,640	4,664	59,781	12.82	18
19	Laundry					19
20	Administrator	2,003	2,017	62,004	30.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	721	721	12,951	17.96	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	69	69	1,399	20.28	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	1,864	1,869	51,340	27.47	33
34	TOTAL (lines 1 - 33)	46,414	47,413	\$ 764,032 *	\$ 16.11	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 19,350	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,184	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	8 462	L10, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	8 \$ 21,996		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	19 \$ 675	L10,C3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	4 82	L10,C3	52
53	TOTAL (lines 50 - 52)	23 \$ 757		53

Enfield Rehab Health Care Ct

0053157

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,832	1,837	51,028	27.78
Transportation	32	32	312	9.75
TOTAL	<u>1,864</u>	<u>1,869</u>	<u>51,340</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	
William Johnson	Administrator	0	\$ 21,579	Workers' Compensation Insurance	\$ 11,865	IDPH License Fee	\$ 3,980	
Jessica Webb	Administrator	0	40,425	Unemployment Compensation Insurance	10,368	Advertising: Employee Recruitment		
				FICA Taxes	52,422	Health Care Worker Background Check		
				Employee Health Insurance	4,399	(Indicate # of checks performed <u>9</u>)		
				Employee Meals		Patient Background Checks	18 543	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	806	
				Employee Relations	200	Miscellaneous Dues & Subscriptions	0	
				Home Office Allocation	3,279	Home Office Allocation	986	
				Employee Retirement	26			
				Administrator Benefits	12,396			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,004	TOTAL (agree to Schedule V, line 22, col.8)		\$ 94,955		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 57,900				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 57,900				In-State Travel	
C. Professional Services								
Vendor/Payee	Type		Amount				Seminar Expense	(69)
Ability Network	Computer Services		\$ 5,423				Home Office Allocation	6
Frontier	Computer Services		824				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,247				TOTAL (agree to Sch. V, line 24, col. 8)	\$ (63)

* Attach copy of IMRF notifications

**See instructions.

Enfield Rehab Health Care Ct

0053157

Period Beginning

1/1/2020

Period End

12/31/2020

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,247
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	111
Duane Morris	Legal	156
Lexis Nexis	Legal	3
Livingston, Barger, Brant, Schroeder	Legal	6
Miller, Hall, Triggs	Legal	19
Miscellaneous	Legal	7
SB2	Legal	58
SmithAmundsen LLC	Legal	356
Sorling Northrup	Legal	102
Illinois Secretary of State	Legal	117
CliftonLarsonAllen	Accounting	442
Ginoli & Co.	Accounting	629
Ability Network	Computer Services	1,136
Allscripts	Computer Services	179
AOD Matrix Care	Computer Services	1,994
AT&T	Computer Services	2
ATS	Computer Services	109
CCH	Computer Services	6
Charter Communications	Computer Services	10
Citrix Systems	Computer Services	34
Comcast	Computer Services	12
ITSavvy	Computer Services	52
Kemper Technology	Computer Services	259
Miscellaneous	Computer Services	50
Pearl Technology	Computer Services	47
Stratus Networks	Computer Services	206
TR Professional	Computer Services	4
David Budde	Other Prof Fees	5
DJ Howard and Associates	Other Prof Fees	9
Getzler Henrich & Associates	Other Prof Fees	35
LRI Consulting Services	Other Prof Fees	34
McQuellon Consulting	Other Prof Fees	22
Miscellaneous	Other Prof Fees	40
Optimizer	Other Prof Fees	18
Registered Agent Solutions	Other Prof Fees	10
RSM McGladrey	Other Prof Fees	113
SB2	Other Prof Fees	144
Sedgwick CMS	Other Prof Fees	194
Tarver Program Consultants	Other Prof Fees	27
Total (agree to Schedule V, line 19, column 8)		<u>13,004</u>

Enfield Rehab Health Care Ct

0053157

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,464
Auto Repairs		1,005
Mileage-Travel		-
Home Office Allocation		1,380
		<u>3,849</u>

Facility Name & ID Number Enfield Rehab Health Care Ct# 0053157Report 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. \$ 5,921 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. \$ 67,806
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,079
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees.