		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: 0050930

Facility Name: Illini Heritage Rehab HC

Address: 1315 Curt Dr Bx 6179 (Number) Champaign (City) 61820 (Zip Code)

County: Champaign

Telephone Number: (217) 352-5707 **Fax #** (217)352-2607

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1996

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid Preparer

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

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

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,245	3,210	845	16,300	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,245	3,210	845	16,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.43%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 12/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 512

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Illini Heritage Rehab HC # 0050930 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	142,870	17,846	433	161,149		161,149	4,340	165,489			1
2	Food Purchase		116,115		116,115		116,115	(927)	115,188			2
3	Housekeeping	120,731	31,775		152,506		152,506	84	152,590			3
4	Laundry	21,581	5,480		27,061		27,061		27,061			4
5	Heat and Other Utilities			66,865	66,865		66,865	296	67,161			5
6	Maintenance	39,481	4,867	17,896	62,244		62,244	4,167	66,411			6
7	Other (specify):*											7
8	**TOTAL General Services**	324,663	176,083	85,194	585,940		585,940	7,960	593,900			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,006,943	72,005	5,468	1,084,416		1,084,416	3,982	1,088,398			10
10a	Therapy			170,917	170,917		170,917		170,917			10a
11	Activities	28,209	506		28,715		28,715	10	28,725			11
12	Social Services	36,000			36,000		36,000		36,000			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,071,152	72,511	188,385	1,332,048		1,332,048	3,992	1,336,040			16
	C. General Administration											
17	Administrative	65,004		146,700	211,704		211,704	(122,563)	89,141			17
18	Directors Fees											18
19	Professional Services			14,902	14,902		14,902	14,257	29,159			19
20	Dues, Fees, Subscriptions & Promotions			1,338	1,338		1,338	2,222	3,560			20
21	Clerical & General Office Expenses	34,952	2,697	15,189	52,838		52,838	26,879	79,717			21
22	Employee Benefits & Payroll Taxes			161,436	161,436		161,436	7,388	168,824			22
23	Inservice Training & Education							45	45			23
24	Travel and Seminar							14	14			24
25	Other Admin. Staff Transportation			2,117	2,117		2,117	3,109	5,226			25
26	Insurance-Prop.Liab.Malpractice			23,038	23,038		23,038	25,020	48,058			26
27	Other (specify):*											27
28	**TOTAL General Administration**	99,956	2,697	364,720	467,373		467,373	(43,629)	423,744			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,495,771	251,291	638,299	2,385,361		2,385,361	(31,677)	2,353,684			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 Illini Heritage Rehab HC #0050930 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,004	15,004		15,004	46,812	61,816			30
31	Amortization of Pre-Op. & Org.							5,268	5,268			31
32	Interest			233	233		233	75,588	75,821			32
33	Real Estate Taxes							33,413	33,413			33
34	Rent-Facility & Grounds			176,757	176,757		176,757	(176,757)				34
35	Rent-Equipment & Vehicles			12,657	12,657		12,657	1,576	14,233			35
36	Other (specify):*											36
37	**TOTAL Ownership**			204,651	204,651		204,651	(14,100)	190,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,355		28,355		28,355		28,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,452	116,452		116,452		116,452			42
43	Other (specify):*			118,823	118,823		118,823	(118,823)				43
44	**TOTAL Special Cost Centers**		28,355	235,275	263,630		263,630	(118,823)	144,807			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,495,771	279,646	1,078,225	2,853,642		2,853,642	(164,600)	2,689,042			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 Illini Heritage Rehab HC # 0050930 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(927)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,125)	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	(5,889)	30		9
10	Interest and Other Investment Income	(57)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58)	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	(63,334)	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	(41,000)	43		24
25	Fund Raising, Advertising and Promotional	(550)	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	(6,863)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (125,803)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(38,797)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (38,797)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (164,600)		37

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

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

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

Illini Heritage Rehab HC

ID# 0050930

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,617)	43	1
2	X-Rays-Part A	(726)	43	2
3	Miscellaneous Revenue Offset of Office Supplies	(32)	21	3
4	Offset Transportation Revenue	10	11	4
5	Miscellaneous Revenue Offset of Nursing Supplies	(85)	10	5
6	Disallowed Special Events	(413)	43	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,863)		49

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,340	$ 4,340	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%	84	84	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	296	296	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,607	2,607	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	4,067	4,067	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	146,700	Petersen Health Care Management, Inc.	100.00%	24,137	(122,563)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,257	14,257	12
13	V								13
14	Total			$ 146,700			$ 49,788	$ * (96,912)	14

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

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 2,222	$ 2,222	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	26,911	26,911	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,388	7,388	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	45	45	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	14	14	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,109	3,109	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	474	474	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	4,393	4,393	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	214	214	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	171	171	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,576	1,576	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			$			$ 46,517	$ * 46,517	39

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

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Illini Land LLC	100.00%	$ 1,560	$ 1,560	15
16	V	19	Professional Fees		Illini Land LLC	100.00%			16
17	V	21	Equipment	$	Illini Land LLC	100.00%			17
18	V	26	Property Insurance		Illini Land LLC	100.00%	14,826	14,826	18
19	V	26	Mortgage Insurance		Illini Land LLC	100.00%	9,720	9,720	19
20	V	30	Depreciation		Illini Land LLC	100.00%	48,308	48,308	20
21	V	31	Amortization		Illini Land LLC	100.00%	5,268	5,268	21
22	V	32	Interest		Illini Land LLC	100.00%	75,431	75,431	22
23	V	33	Real Estate Taxes		Illini Land LLC	100.00%	33,242	33,242	23
24	V	34	Rent-Facility & Grounds	176,757	Illini Land LLC	100.00%		(176,757)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 176,757			$ 188,355	$ * 11,598	39

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

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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 Quali	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 Illini Heritage Rehab HC # 0050930 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 Illini Heritage Rehab HC # 0050930 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 Illini Heritage Rehab HC # 0050930 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 Illini Heritage Rehab HC # 0050930 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 Illini Heritage Rehab HC # 0050930 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	$ 341,562	$ 341,562	16,300	$ 4,340	1
2	2	Food	Resident Days	1,282,791	75	0	0	16,300	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	6,607	16,300	84	3
4	5	Utilities	Resident Days	1,282,791	75	23,319	23,319	16,300	296	4
5	6	Maintenance	Resident Days	1,282,791	75	205,134	205,134	16,300	2,607	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	16,300	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	16,300	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,056	320,056	16,300	4,067	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	16,300	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	16,300	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	1,899,565	16,300	24,137	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,027	1,122,027	16,300	14,257	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,865	174,865	16,300	2,222	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,876	2,117,876	16,300	26,911	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,391	581,391	16,300	7,388	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,516	3,516	16,300	45	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,091	1,091	16,300	14	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,703	244,703	16,300	3,109	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,295	37,295	16,300	474	19
20	30	Depreciation	Resident Days	1,282,791	75	345,754	345,754	16,300	4,393	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	16,300	0	21
22	32	Interest	Resident Days	1,282,791	75	16,844	16,844	16,300	214	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,452	13,452	16,300	171	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,023	124,023	16,300	1,576	24
25	TOTALS					$ 7,579,080	$ 7,579,080		$ 96,305	25

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capmark		X	Mortgage	$9,536.20	08/01/02	$ 1,615,000	$ 1,182,368	9/1/37	0.0630	$ 75,664	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$9,536.20		$ 1,615,000	$ 1,182,368			$ 75,664	9
	B. Non-Facility Related*											
10								Interest Income Offset			(57)	10
11								Home Office Allocation-PHCM			214	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 157	14
15	TOTALS (line 9+line14)						$ 1,615,000	$ 1,182,368			$ 75,821	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.)

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 34,000	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.)		$ 33,242	2
3. Under or (over) accrual (line 2 minus line 1).		$ (758)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,000	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**		171	
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.		$ 33,413	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	29,479	8
	2016	29,256	9
	2017	32,631	10
	2018	32,495	11
	2019	33,242	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 Illini Heritage Nursing Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0050930

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	41-20-02-132-008	Long-Term Care Facility	$ 33,242.24	$ 33,242.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,242.24	$ 33,242.24

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 Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,312 B. General Construction Type: Exterior Brick Frame Block 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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 184,186 2. Number of Years Over Which it is Being Amortized: 35

3. Current Period Amortization: 5,268 4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1996	$ 41,400	1
2					2
3	TOTALS			$ 41,400	3

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1996	1974	$ 979,800	$	27.5	$ 35,629	$ 35,629	$ 855,096	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Paving			1997	16,431		39	421	421	9,841	9
10	Water Heater			1997	4,300		39	110	110	2,626	10
11	Laundry Repair			1997	1,633		39	42	42	992	11
12	Remodeling			1997	30,803		39	790	790	19,948	12
13	Remodeling			1997	11,351		15			11,351	13
14	Paving			1998	2,900		39	74	74	1,674	14
15	Tiling			1999	38,000		27.5	1,382	1,382	29,770	15
16	Birdhouse			1999	4,043		27.5	147	147	3,105	16
17	Parking Lot Paving			1999	5,900		27.5	215	215	4,559	17
18	Roof Repair			2003	4,160		39	107	107	1,868	18
19	Blinds			2007	4,571		10			4,571	19
20	Water Heaters			2007	11,705		15	780	780	10,530	20
21	Roof Replacement			2007	87,945		20	4,398	4,398	56,475	21
22	Windows			2008	16,695		20	834	834	10,425	22
23	Door			2008	2,793		15	186	186	2,325	23
24	Blinds			2008	3,481		10			3,481	24
25	Parking Lot Repair			2011	5,816		7			5,816	25
26	Door Replacement			2013	2,911		7	207	207	2,911	26
27	Window Replacements			2016	38,840		25	1,554	1,554	6,993	27
28	Roof Repair			2016	4,560		7	652	652	2,934	28
29	Electric Heater			2017	5,307		7	758	758	2,653	29
30	Sidewalk and Patio Repair			2017	3,500		7	500	500	1,750	30
31	Gutter Repair			2017	4,200		7	600	600	2,100	31
32	Air Conditioner			2018	10,535		15	702	702	1,755	32
33	Parking Lot Asphalt Resurfacing			2020	33,840		15	1,128	1,128	1,128	33
34											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 Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58	Building Booked			48,308			(48,308)		58
59	Building Improvement Booked			13,413			(13,413)		59
60									60
61	2020-Home Office Allocation-Building Improvements		8,241			198	198		61
62	2020-Home Office Allocation-Land Improvements		827			52	52		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,345,088	$ 61,721		$ 51,466	$ (10,255)	$ 1,056,677	70

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

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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	$ 49,910	$ 2,590	$ 5,516	$ 2,926	5-10 yrs.	$ 35,002	71
72	Current Year Purchases	9,666	1,381	691	(690)	7 yrs.	691	72
73	Fully Depreciated Assets	382,602					382,602	73
74	Home Office Allocation			4,143	4,143			74
75	TOTALS	$ 442,178	$ 3,971	$ 10,350	$ 6,379		$ 418,295	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	Van	2012	$ 16,131	$	$	$		$ 16,131	76
77										77
78										78
79										79
80	TOTALS			$ 16,131	$	$	$		$ 16,131	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)	$ 1,844,797	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,692	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,816	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,876)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,491,103	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 Illini Heritage Rehab HC # 0050930 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

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: ____ *

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	$

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: $ 14,233 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.

Illini Heritage Rehab HC
0050930
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	$	6,774
Dishwasher		701
Copier		5,182
Home Office Allocation		1,576
		14,233

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	4,688	$ 70,313	$	4,688	$ 70,313	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,312	34,673		2,312	34,673	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,395	65,931		4,395	65,931	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 prescrpts				28,355		28,355	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			$	11,395	$ 170,917	$ 28,355	11,395	$ 199,272	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 Illini Heritage Rehab HC # 0050930 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,329,802	$ 1,330,002	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,203)	1,541,941	1,541,941	3
4	Supply Inventory (priced at Cost)	9,085	9,085	4
5	Short-Term Investments			5
6	Prepaid Insurance	12,250	19,796	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	278,200	278,200	8
9	Other(specify): Employee Education Loans	173	173	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,171,451	$ 3,179,197	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		41,400	13
14	Buildings, at Historical Cost		988,041	14
15	Leasehold Improvements, at Historical Cost	227,114	357,047	15
16	Equipment, at Historical Cost	89,715	458,309	16
17	Accumulated Depreciation (book methods)	(195,888)	(1,491,103)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		184,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(96,559)	20
21	Restricted Funds		550,179	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): RE Entity Escrow Reserves	877,500	877,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 998,441	$ 1,869,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,169,892	$ 5,048,197	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 253,469	$ 260,907	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,444	61,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	83,448	83,448	31
32	Accrued Real Estate Taxes(Sch.IX-B)		34,000	32
33	Accrued Interest Payable		6,207	33
34	Deferred Compensation	581,777	1,062,894	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	277	277	36
37	Accrued Management Fees	818,506	818,506	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,798,921	$ 2,327,683	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,182,368	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	2,918,304	3,026,849	43
44	Loan Payable-MCAD Adv. Payment	693,300	693,300	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,611,604	$ 4,902,517	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,410,525	$ 7,230,200	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,240,633)	$ (2,182,003)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,169,892	$ 5,048,197	48

***(See instructions.)**

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,921,403)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	(165,320)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,086,723)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	846,090	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)**	$ 846,090	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,240,633)	24 *

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

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,218,186	1
2	Discounts and Allowances for all Levels	(688,239)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,529,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	357,961	6
7	Oxygen	42	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 358,003	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	927	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,485	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,599	20
21	Other Medical Services	2,137	21
22	Laundry	61	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,209	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	57	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 57	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Transportation Revenue**	(10)	28
28a	**Miscellaneous Revenue**	764,526	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 764,516	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,699,732	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	585,940	31
32	Health Care	1,332,048	32
33	General Administration	467,373	33
	B. Capital Expense		
34	Ownership	204,651	34
	C. Ancillary Expense		
35	Special Cost Centers	147,178	35
36	Provider Participation Fee	116,452	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,853,642	40
41	**Income before Income Taxes (line 30 minus line 40)****	846,090	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 846,090	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,787,845	44
45	Private Pay - Net Inpatient Revenue	570,410	45
46	Medicare - Net Inpatient Revenue	117,350	46
47	Other-(specify) **Insurance Net Inpatient Revenue**	54,342	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,529,947	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 Illini Heritage Rehab HC # 0050930 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 74,440	$ 35.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,345	4,434	124,643	28.11	3
4	Licensed Practical Nurses	10,972	11,541	305,389	26.46	4
5	CNAs & Orderlies	25,491	26,164	418,147	15.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,032	1,102	17,190	15.60	8
9	Activity Director	1,725	1,745	26,768	15.34	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	36,000	17.31	11
12	Dietician					12
13	Food Service Supervisor	1,975	1,975	38,626	19.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,411	10,567	104,244	9.87	15
16	Dishwashers					16
17	Maintenance Workers	1,999	2,053	39,481	19.23	17
18	Housekeepers	10,869	11,197	120,731	10.78	18
19	Laundry	1,970	2,049	21,581	10.53	19
20	Administrator	2,080	2,080	65,004	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,794	1,803	34,952	19.39	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) Page 20A	2,256	2,282	68,575	30.05	33
34	TOTAL (lines 1 - 33)	81,079	83,152	$ 1,495,771 *	$ 17.99	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	8	$ 433	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,087	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	381	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)	14	$ 17,901		49

C. CONTRACT NURSES

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

Illini Heritage Rehab HC
0050930
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	2,153	2,179	67,134	30.81
Transportation	103	103	1,441	13.99
TOTAL	2,256	2,282	68,575	

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ivory Banks	Administrator	0	$ 65,004
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 65,004

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 146,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 146,700

C. Professional Services

Vendor/Payee	Type	Amount
Comcast Cable	Computer Services	$ 1,310
Allscripts	Computer Services	2,273
Ability Network	Computer Services	6,149
Ginoli	Accounting Fees	5,020
Illinois Secretary of State	Legal Filing Fees	150
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 14,902

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,529
Unemployment Compensation Insurance	18,864
FICA Taxes	107,580
Employee Health Insurance	5,932
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	811
Home Office Allocation	7,388
Employee Retirement	724
Administrator Benefits	12,996
TOTAL (agree to Schedule V, line 22, col.8)	$ 168,824

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 25)	
Patient Background Checks	800
Miscellaneous Licenses & Permits	538
Home Office Allocation	2,222
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,560

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	14
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14

* Attach copy of IMRF notifications

**See instructions.

Illini Heritage Rehab HC
0050930
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)		14,902
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	251
Duane Morris	Legal	351
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	13
Miller, Hall, Triggs	Legal	43
Miscellaneous	Legal	16
SB2	Legal	130
SmithAmundsen LLC	Legal	802
Sorling Northrup	Legal	229
CliftonLarsonAllen	Accounting	997
Ginoli & Co.	Accounting	711
Ability Network	Computer Services	2,559
Allscripts	Computer Services	404
AOD Matrix Care	Computer Services	4,493
AT&T	Computer Services	5
ATS	Computer Services	245
CCH	Computer Services	14
Charter Communications	Computer Services	23
Citrix Systems	Computer Services	76
Comcast	Computer Services	26
ITSavvy	Computer Services	118
Kemper Technology	Computer Services	584
Miscellaneous	Computer Services	168
Pearl Technology	Computer Services	106
Stratus Networks	Computer Services	464
TR Professional	Computer Services	10
David Budde	Other Prof Fees	10
DJ Howard and Associates	Other Prof Fees	19
Getzler Henrich & Associates	Other Prof Fees	79
LRI Consulting Services	Other Prof Fees	77
McQuellon Consulting	Other Prof Fees	49
Miscellaneous	Other Prof Fees	38
Optimizer	Other Prof Fees	42
Registered Agent Solutions	Other Prof Fees	23
RSM McGladrey	Other Prof Fees	254
SB2	Other Prof Fees	324
Sedgwick CMS	Other Prof Fees	437
Tarver Program Consultants	Other Prof Fees	60
Total (agree to Schedule V, line 19, column 8)		29,159

Illini Heritage Rehab HC
0050930
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	1,064
Auto Repairs		1,053
Home Office Allocation		3,309
		5,426

Facility Name & ID Number Illini Heritage Rehab HC # 0050930 Report Period Beginning: 1/1/2020 Ending: 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. $ **14,796** 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. $ **116,452**
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. $ **927**

(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 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.