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: 0056069

Facility Name: Kewanee Care Home

Address: 144 Junior Avenue (Number) Kewanee (City) 61443 (Zip Code)

County: Henry

Telephone Number: (309) 853-4429 **Fax #** (309) 853-4400

HFS ID Number:

Date of Initial License for Current Owners: 06/01/76

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 Kewanee Care Home # 0056069 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	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,805	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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		3,824	2,746	6,570	8
9	SNF/PED					9
10	ICF	13,152			13,152	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,152	3,824	2,746	19,722	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.32%

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 6/1/1976

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/1976 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 2,593

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 Kewanee Care Home # 0056069 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	159,733	24,682		184,415		184,415	5,251	189,666			1
2	Food Purchase		136,476		136,476		136,476	(4,767)	131,709			2
3	Housekeeping	89,800	27,835		117,635		117,635	102	117,737			3
4	Laundry	56,716	4,881		61,597		61,597		61,597			4
5	Heat and Other Utilities			43,034	43,034		43,034	359	43,393			5
6	Maintenance	35,781	5,783	79,910	121,474		121,474	3,154	124,628			6
7	Other (specify):*											7
8	**TOTAL General Services**	342,030	199,657	122,944	664,631		664,631	4,099	668,730			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,157,812	103,323	8,352	1,269,487		1,269,487	2,955	1,272,442			10
10a	Therapy			335,462	335,462		335,462		335,462			10a
11	Activities	92,370			92,370		92,370	(3,961)	88,409			11
12	Social Services	27,946			27,946		27,946		27,946			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,278,128	103,323	355,814	1,737,265		1,737,265	(1,006)	1,736,259			16
	C. General Administration											
17	Administrative	80,004		221,600	301,604		301,604	(192,396)	109,208			17
18	Directors Fees											18
19	Professional Services			75,802	75,802		75,802	(44,605)	31,197			19
20	Dues, Fees, Subscriptions & Promotions			3,362	3,362		3,362	2,371	5,733			20
21	Clerical & General Office Expenses	872	2,695	15,602	19,169		19,169	32,462	51,631			21
22	Employee Benefits & Payroll Taxes			191,534	191,534		191,534	8,938	200,472			22
23	Inservice Training & Education							54	54			23
24	Travel and Seminar							17	17			24
25	Other Admin. Staff Transportation			13,546	13,546		13,546	3,762	17,308			25
26	Insurance-Prop.Liab.Malpractice			33,833	33,833		33,833	14,125	47,958			26
27	Other (specify):*											27
28	**TOTAL General Administration**	80,876	2,695	555,279	638,850		638,850	(175,272)	463,578			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,701,034	305,675	1,034,037	3,040,746		3,040,746	(172,179)	2,868,567			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 Kewanee Care Home #0056069 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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,249	3,249		3,249	73,892	77,141			30
31	Amortization of Pre-Op. & Org.							319,745	319,745			31
32	Interest							755,665	755,665			32
33	Real Estate Taxes			37,994	37,994		37,994	20,271	58,265			33
34	Rent-Facility & Grounds			846,398	846,398		846,398	(846,398)				34
35	Rent-Equipment & Vehicles			27,414	27,414		27,414	1,907	29,321			35
36	Other (specify):*											36
37	**TOTAL Ownership**			915,055	915,055		915,055	325,082	1,240,137			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,361		63,361		63,361		63,361			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,631	148,631		148,631		148,631			42
43	Other (specify):*	35,003	1,230	19,825	56,058		56,058	(56,058)				43
44	**TOTAL Special Cost Centers**	35,003	64,591	168,456	268,050		268,050	(56,058)	211,992			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,736,037	370,266	2,117,548	4,223,851		4,223,851	96,845	4,320,696			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 Kewanee Care Home # 0056069 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	(4,767)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,235)	30		9
10	Interest and Other Investment Income	(197)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(463)	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	(19,973)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(67,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,810)	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	(40,258)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (149,203)		$	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)	246,048	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 246,048		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 96,845		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

Kewanee Care Home

ID# 0056069

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,138)	43	1
2	X-Rays-Part A	3,229	43	2
3	Offset of Transportation Income	(3,961)	11	3
4	Offset Chamber of Commerce Dues	(420)	20	4
5	Offset of Office Supplies Income	(99)	21	5
6	Offset of Nursing Supplies Income	(1,966)	21	6
7	Disallowed Special Events	143	43	7
8	Disallowed Marketing Salaries	(35,003)	43	8
9	Disallowed Resident Flowers	(43)	43	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
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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**	(40,258)		49

Facility Name & ID Number Kewanee Care Home # 0056069 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%	$ 5,251	$ 5,251	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%	102	102	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	359	359	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,154	3,154	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%	4,921	4,921	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	221,600	Petersen Health Care Management, Inc.	100.00%	29,204	(192,396)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	17,250	17,250	12
13	V								13
14	Total			$ 221,600			$ 60,241	$ * (161,359)	14

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

Facility Name & ID Number Kewanee Care Home # 0056069 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%	$ 2,688	$ 2,688	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	32,561	32,561	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	8,938	8,938	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	54	54	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	17	17	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,762	3,762	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	573	573	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	5,316	5,316	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	259	259	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	207	207	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,907	1,907	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			$			$ 56,282	$ * 56,282	39

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

Facility Name & ID Number Kewanee Care Home # 0056069 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	1	Dietary	$	Petersen Health Junction, LLC	100.00%	$	$	15
16	V	2	Food		Petersen Health Junction, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Junction, LLC	100.00%			17
18	V	5	Utilities		Petersen Health Junction, LLC	100.00%			18
19	V	6	Maintenance		Petersen Health Junction, LLC	100.00%			19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%			20
21	V	9	Medical Director		Petersen Health Junction, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Junction, LLC	100.00%			22
23	V	10A	Therapy		Petersen Health Junction, LLC	100.00%			23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%			24
25	V	17	Administrative		Petersen Health Junction, LLC	100.00%			25
26	V	19	Professional Services		Petersen Health Junction, LLC	100.00%	5,645	5,645	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Junction, LLC	100.00%	103	103	27
28	V	21	Clerical and General Office		Petersen Health Junction, LLC	100.00%			28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Junction, LLC	100.00%			29
30	V	23	Inservice Training & Education		Petersen Health Junction, LLC	100.00%			30
31	V	24	Travel and Seminar		Petersen Health Junction, LLC	100.00%			31
32	V	25	Other Admin. Staff Transport.		Petersen Health Junction, LLC	100.00%			32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Junction, LLC	100.00%			33
34	V	30	Depreciation		Petersen Health Junction, LLC	100.00%			34
35	V	31	Amortization		Petersen Health Junction, LLC	100.00%			35
36	V	32	Interest		Petersen Health Junction, LLC	100.00%	19,608	19,608	36
37	V	33	Real Estate Taxes		Petersen Health Junction, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Junction, LLC	100.00%			38
39	Total			$			$ 25,356	$ * 25,356	39

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

Facility Name & ID Number Kewanee Care Home # 0056069 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	$	Kewanee Land, LLC	100.00%	$	$	15
16	V	19	Professional Services	$	Kewanee Land, LLC	100.00%			16
17	V	21	Equipment		Kewanee Land, LLC	100.00%			17
18	V	26	Insurance-Property		Kewanee Land, LLC	100.00%	8,188	8,188	18
19	V	26	Insurance-Mortgage Insurance		Kewanee Land, LLC	100.00%	5,364	5,364	19
20	V	30	Depreciation		Kewanee Land, LLC	100.00%	82,811	82,811	20
21	V	31	Amortization		Kewanee Land, LLC	100.00%	319,745	319,745	21
22	V	32	Interest	238	Kewanee Land, LLC	100.00%	736,233	735,995	22
23	V	33	Real Estate Taxes		Kewanee Land, LLC	100.00%	20,064	20,064	23
24	V	34	Rent-Income and Grounds	846,398	Kewanee Land, LLC	100.00%		(846,398)	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			$ 846,636			$ 1,172,405	$ * 325,769	39

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

Facility Name & ID Number Kewanee Care Home # 0056069 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 Kewanee Care Home # 0056069 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 Kewanee Care Home # 0056069 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 Kewanee Care Home # 0056069 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 Kewanee Care Home # 0056069 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						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 Kewanee Care Home # 0056069 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	$ 398,718	19,722	$ 5,251	1
2	2	Food	Resident Days	1,282,791	75	0	0	19,722	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	19,722	102	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	19,722	359	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	19,722	3,154	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	19,722	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	19,722	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	19,722	4,921	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	19,722	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	19,722	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	19,722	29,204	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	19,722	17,250	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	19,722	2,688	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	19,722	32,561	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	19,722	8,938	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	19,722	54	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	19,722	17	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	19,722	3,762	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	19,722	573	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	19,722	5,316	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	19,722	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	19,722	259	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	19,722	207	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	19,722	1,907	24
25	TOTALS					$ 7,579,077	$ 11,195,006		$ 116,523	25

Facility Name & ID Number Kewanee Care Home # 0056069 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 Junction, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: ((309)691-8113
Fax Number: ((309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	41,016	2	$		12,060	$	1
2	2	Food	Resident Days	41,016	2			12,060		2
3	3	Housekeeping	Resident Days	41,016	2			12,060		3
4	5	Utilities	Resident Days	41,016	2			12,060		4
5	6	Maintenance	Resident Days	41,016	2			12,060		5
6	7	Mgmt. Allocation of Benefits	Resident Days	41,016	2			12,060		6
7	9	Medical Director	Resident Days	41,016	2			12,060		7
8	10	Nursing and Medical Records	Resident Days	41,016	2			12,060		8
9	10A	Therapy	Resident Days	41,016	2			12,060		9
10	15	Mgmt. Allocation of Benefits	Resident Days	41,016	2			12,060		10
11	17	Administrative	Resident Days	41,016	2			12,060		11
12	19	Professional Services	Resident Days	41,016	2	19,197		12,060	5,645	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	41,016	2	350		12,060	103	13
14	21	Clerical and General Office	Resident Days	41,016	2			12,060		14
15	22	Employee Benefits and Payroll Ta	Resident Days	41,016	2			12,060		15
16	23	Inservice Training & Education	Resident Days	41,016	2			12,060		16
17	24	Travel and Seminar	Resident Days	41,016	2			12,060		17
18	25	Other Admin. Staff Transport.	Resident Days	41,016	2			12,060		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	41,016	2			12,060		19
20	30	Depreciation	Resident Days	41,016	2			12,060		20
21	31	Amortization	Resident Days	41,016	2			12,060		21
22	32	Interest	Resident Days	41,016	2	66,688		12,060	19,608	22
23	33	Real Estate Taxes	Resident Days	41,016	2			12,060		23
24	35	Rent-Equipment & Vehicles	Resident Days	41,016	2			12,060		24
25	TOTALS					$ 86,235	$		$ 25,356	25

Facility Name & ID Number Kewanee Care Home # 0056069 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**		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	Capital Finance Group		X	Mortgage	Varies	1/1/14	$ 3,870,400	$ Paid	3/31/20	Varies	$ 21,365	1
2	Sector		X	Mortgage	Varies	4/1/20	7,368,773	7,368,773	3/31/23	Varies	714,868	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 11,239,173	$ 7,368,773			$ 736,233	9
	B. Non-Facility Related*											
10								Interest Income Offset			(435)	10
11								Home Office Allocation-PHCM			259	11
12								Home Office Allocation-PHJ			19,608	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 19,432	14
15	TOTALS (line 9+line14)						$ 11,239,173	$ 7,368,773			$ 755,665	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 Kewanee Care Home # 0056069 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.**	$ 60,192	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.)		$ 58,250	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,942)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,000	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Home Office Allocation** 207	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 58,265	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	55,602	8
	2016	55,509	9
	2017	58,315	10
	2018	58,433	11
	2019	58,250	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 Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0053132

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.	25-05-281-017	901 W. Mill St.	$ 132.90	$ 132.90
2.	25-04-151-011	144 Junior Ave.	$ 58,016.48	$ 58,016.48
3.	25-04-152-001	821 Dewey Ave.	$ 100.82	$ 100.82
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,250.20	$ 58,250.20

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 Kewanee Care Home # 0056069 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,548 B. General Construction Type: Exterior Brick Frame Steel 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: 368,977 2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 319,745 4. Dates Incurred: 2020

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	42,000	1976	$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		$ 50,621	3

Facility Name & ID Number Kewanee Care Home # 0056069 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			1976		$ 381,128	$	30	$	$	$ 381,128	4
5			1998	1998	753,696		40	18,842	18,842	425,999	5
6			2002	2002	661,677		40	16,542	16,542	275,850	6
7											7
8											8
	Improvement Type**										
9	1984-1999 Fully Depreciated Assets				265,947					265,947	9
10	Beauty Salon			2000	943		20	47	47	917	10
11	Tile Flooring			2000	10,219		20	511	511	10,022	11
12	Lot/House Razed			2000	5,061		20			5,061	12
13	Concrete			2001	900		15			900	13
14	Landscaping			2001	1,045		15			1,045	14
15	Lighting			2001	3,438		39	88	88	1,672	15
16	Blinds/Curtains			2001	9,500		7			9,500	16
17	Landscaping			2002	24,614		15			24,614	17
18	Landscaping			2002	4,075		15			4,075	18
19	Architectural			2002	15,602		20			15,602	19
20	Carpeting			2002	2,551		20	128	128	2,240	20
21	Fire System			2002	4,677		20	234	234	4,095	21
22	Landscaping			2003	4,899		15			4,899	22
23	Simplex Time Clock			2004	3,198		10			3,198	23
24	Air Conditioner			2004	2,700		10			2,700	24
25	Side walks			2005	2,065		15	133	133	2,065	25
26	Floor covering			2005	13,891		7			13,891	26
27	Flooring			2006	28,527		25	1,141	1,141	15,404	27
28	Driveway			2007	7,101		15	473	473	5,913	28
29	Boiler			2007	2,895		10			2,895	29
30	Sprinkler System Repair			2008	2,583		5			2,583	30
31	Painting of Dining Room			2008	2,825		39	72	72	828	31
32	Sprinkler System Repair			2008	2,689		5			2,689	32
33	Fencing			2009	3,400		15	226	226	2,373	33
34	Boiler			2010	2,900		20	146	146	1,387	34
35	Compressor Repair			2010	2,639		7			2,639	35
36	Dry Pendent Head Replacement			2011	8,857		7			8,857	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 Kewanee Care Home # 0056069 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	Compressor	2012	2,685		7	189	$ 189	$ 2,685	37
38	Air Conditioner-Central System	2012	2,978		15	198	198	1,485	38
39	Furnace, Air Conditoner, and Boiler	2012	17,929		15	1,195	1,195	10,799	39
40	A/C Repair	2013	3,455		7	494	494	3,211	40
41	Water Pipe Repair	2013	5,861		7	838	838	5,447	41
42	Smoke and Heat	2014	2,742		7	392	392	2,156	42
43	Alarm System	2014	4,344		7	621	621	3,416	43
44	Water Line Repair	2014	2,712		7	387	387	2,129	44
45	Water Pipe Repair	2014	2,550		7	364	364	2,002	45
46	Water Line Repair	2014	3,860		7	551	551	3,031	46
47	Boiler	2014	3,552		15	237	237	1,304	47
48	Dry Pendent Head Replacement	2015	3,973		7	568	568	2,556	48
49	Roof Replacement	2015	110,000		25	4,450	4,450	20,025	49
50	Repair and Reseal of Parking Lot	2016	20,930		15	1,396	1,396	4,886	50
51	Water Pipe Repair	2016	5,157		7	736	736	2,576	51
52	Air Conditioner	2016	6,368		15	424	424	1,484	52
53	Nurse Call System Replacement	2016	5,988		7	856	856	2,996	53
54	Tiling/Carpeting-6 Shower Rooms, 11 Patient Rooms, Halls	2016	97,105		15	6,474	6,474	22,659	54
55	Sprinkler Repair	2017	2,855		7	408	408	1,020	55
56	Furnace and Boiler Repair	2018	2,535		7	362	362	543	56
57	Drywall in Ceiling, Dining Room, Nurses Station Cabinets	2019	44,107		15	1,470	1,470	1,470	57
58	Water Sprinkler Repairs	2019	10,960		7	783	783	783	58
59	Water Heater	2019	3,189		7	228	228	228	59
60	Boiler	2019	3,413		7	244	244	244	60
61	Sprinkler Repair	2019	4,781		7	342	342	342	61
62	Boiler	2020	13,723		15	457	457	457	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,623,994	$		$ 63,247	$ 63,247	$ 1,600,922	70

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

Facility Name & ID Number Kewanee Care Home # 0056069 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	
1	Totals from Page 12A, Carried Forward		$ 2,623,994	$		$ 63,247	$ 63,247	$ 1,600,922	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Land Improvements Booked			2,726			(2,726)		24
25	Building Booked			19,325			(19,325)		25
26	Building Improvement Booked			56,170			(56,170)		26
27									27
28	2020-Home Office Allocation-Building Improvements		9,972			239	239		28
29	2020-Home Office Allocation-Land Improvements		1,000			63	63		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,634,966	$ 78,221		$ 63,549	$ (14,672)	$ 1,600,922	34

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

Facility Name & ID Number Kewanee Care Home # 0056069 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	$ 61,641	$ 6,495	$ 7,779	$ 1,284	5-10 yrs.	$ 33,909	71
72	Current Year Purchases	11,176	1,344	799	(545)	7 yrs.	799	72
73	Fully Depreciated Assets	210,779					210,779	73
74	Home Office Allocation			5,014	5,014			74
75	TOTALS	$ 283,596	$ 7,839	$ 13,592	$ 5,753		$ 245,487	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	2000 Town & Country	2002	35,088	$	$	$		$ 35,088	76
77										77
78										78
79										79
80	TOTALS			$ 35,088	$	$	$		$ 35,088	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)	$ 3,004,271	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,060	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,141	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,919)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,881,497	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 Kewanee Care Home # 0056069 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: $ 29,321 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.

Kewanee Care Home
0056069
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	$ 22,018
Dishwasher	1,211
Copier	4,185
Home Office Allocation	1,907
	29,321

Facility Name & ID Number Kewanee Care Home # 0056069 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	$	9,116	$ 136,742	$	9,116	$ 136,742	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,211	33,167		2,211	33,167	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,037	165,553		11,037	165,553	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				63,361		63,361	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			$	22,364	$ 335,462	$ 63,361	22,364	$ 398,823	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.

STATE OF ILLINOIS

Facility Name & ID Number Kewanee Care Home # 0056069 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	$ (35,712)	$ (35,712)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 215,637)	2,256,610	2,256,610	3
4	Supply Inventory (priced at Cost)	12,965	12,965	4
5	Short-Term Investments			5
6	Prepaid Insurance	46,979	30,268	6
7	Other Prepaid Expenses	1,360,869	1,413,871	7
8	Accounts Receivable (owners or related parties)		2,911,870	8
9	Other(specify): Employee Education Loans	2,611	2,611	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,644,322	$ 6,592,483	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,621	13
14	Buildings, at Historical Cost		1,806,473	14
15	Leasehold Improvements, at Historical Cost		828,493	15
16	Equipment, at Historical Cost	37,826	318,684	16
17	Accumulated Depreciation (book methods)	(35,349)	(1,881,497)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		368,977	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(139,128)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Const. In Progress		37,248	22
23	Other(specify): Intercompany Loans	72,162	630,893	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 74,639	$ 2,020,764	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,718,961	$ 8,613,247	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 865,982	$ 865,982	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,427	88,427	30
31	Accrued Taxes Payable (excluding real estate taxes)	95,673	95,673	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	60,000	32
33	Accrued Interest Payable		88,369	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	311	311	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,110,393	$ 1,198,762	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,368,773	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,288,157	993,924	43
44	Loans-MCAD Adv. Payment and PPP	540,600	540,600	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,828,757	$ 8,903,297	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,939,150	$ 10,102,059	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 779,811	$ (1,488,812)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,718,961	$ 8,613,247	48

***(See instructions.)**

Facility Name & ID Number Kewanee Care Home # 0056069 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**	$ (1,766,325)	1
2	Restatements (describe):		2
3	**Post-Filing Adjustments Due to Bank Refinancing**	2,025,896	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 259,571	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	493,757	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	26,483	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)**	$ 520,240	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)**	$ 779,811	24 *

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

Facility Name & ID Number Kewanee Care Home # 0056069 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	$ 4,096,149	1
2	Discounts and Allowances for all Levels	(332,119)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,764,030	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	538,408	6
7	Oxygen	4,225	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 542,633	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	4,767	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,181	20
21	Other Medical Services	15,816	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 120,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	197	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 197	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	3,961	28
28a	Miscellaneous Revenue	286,094	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 290,055	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,717,608	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	664,631	31
32	Health Care	1,737,265	32
33	General Administration	638,850	33
	B. Capital Expense		
34	Ownership	915,055	34
	C. Ancillary Expense		
35	Special Cost Centers	119,419	35
36	Provider Participation Fee	148,631	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,223,851	40
41	**Income before Income Taxes (line 30 minus line 40)****	493,757	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 493,757	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,169,891	44
45	Private Pay - Net Inpatient Revenue	662,895	45
46	Medicare - Net Inpatient Revenue	912,905	46
47	Other-(specify) Insurance Net Inpatient Revenue	18,339	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,764,030	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 Kewanee Care Home # 0056069 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	1,566	1,680	$ 54,700	$ 32.56	1
2	Assistant Director of Nursing	17	17	472	27.76	2
3	Registered Nurses	2,608	2,728	85,483	31.34	3
4	Licensed Practical Nurses	12,455	13,036	320,636	24.60	4
5	CNAs & Orderlies	41,179	42,869	623,587	14.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,054	2,085	30,770	14.76	9
10	Activity Assistants					10
11	Social Service Workers	1,878	1,884	27,946	14.83	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,745	13.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,681	12,432	131,988	10.62	15
16	Dishwashers					16
17	Maintenance Workers	1,835	1,984	35,781	18.03	17
18	Housekeepers	8,035	8,318	89,800	10.80	18
19	Laundry	5,485	5,617	56,716	10.10	19
20	Administrator	1,976	2,080	80,004	38.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	58	58	872	15.03	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	150	164	4,671	28.48	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	175	175	4,475	25.57	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	8,988	9,118	160,391	17.59	33
34	TOTAL (lines 1 - 33)	102,220	106,325	$ 1,736,037 *	$ 16.33	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		$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,215	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	40	2,137	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)	40	$ 20,352		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

Kewanee Care Home
0056069
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	1,948	1,955	63,788	32.63
Transportation	4,960	5,083	61,600	12.12
Marketing	2,080	2,080	35,003	16.83
TOTAL	8,988	9,118	160,391	

Facility Name & ID Number Kewanee Care Home # 0056069 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sasha Wilson	Administrator	0	$ 80,004
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,004

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 221,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 221,600

C. Professional Services

Vendor/Payee	Type	Amount
Comcast Communications	Computer Services	$ 839
Ability Network	Computer Services	6,807
Dwight Hollins	Legal Settlement	67,500
Sector	Legal Fees	656
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 75,802

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,340
Unemployment Compensation Insurance	23,236
FICA Taxes	125,305
Employee Health Insurance	5,710
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	867
Home Office Allocation	8,938
Employee Retirement	80
Administrator Benefits	15,996
TOTAL (agree to Schedule V, line 22, col.8)	$ 200,472

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 7)	210
Patient Background Checks 30	2,014
Miscellaneous Licenses & Permits	718
Miscellaneous Dues & Subscriptions	420
Home Office Allocation	2,791
Less: Public Relations Expense	(420)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,733

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	17
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17

**See instructions.

Kewanee Care Home
0056069
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)		75,802
Non-Allowable Legal Settlement		(67,500)
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	304
Duane Morris	Legal	424
Lexis Nexis	Legal	8
Livingston, Barger, Brant, Schroeder	Legal	16
Miller, Hall, Triggs	Legal	52
Miscellaneous	Legal	19
SB2	Legal	157
SmithAmundsen LLC	Legal	970
Sorling Northrup	Legal	277
Capital Finance Group	Legal	1,685
CliftonLarsonAllen	Accounting	2,734
Ginoli & Co.	Accounting	3,293
Ability Network	Computer Services	3,096
Allscripts	Computer Services	489
AOD Matrix Care	Computer Services	5,437
AT&T	Computer Services	6
ATS	Computer Services	296
CCH	Computer Services	17
Charter Communications	Computer Services	27
Citrix Systems	Computer Services	92
Comcast	Computer Services	32
ITSavvy	Computer Services	143
Kemper Technology	Computer Services	706
Miscellaneous	Computer Services	205
Pearl Technology	Computer Services	128
Stratus Networks	Computer Services	561
TR Professional	Computer Services	12
David Budde	Other Prof Fees	12
DJ Howard and Associates	Other Prof Fees	24
Getzler Henrich & Associates	Other Prof Fees	96
LRI Consulting Services	Other Prof Fees	93
McQuellon Consulting	Other Prof Fees	59
Miscellaneous	Other Prof Fees	46
Optimizer	Other Prof Fees	50
Registered Agent Solutions	Other Prof Fees	28
RSM McGladrey	Other Prof Fees	307
SB2	Other Prof Fees	392
Sedgwick CMS	Other Prof Fees	529
Tarver Program Consultants	Other Prof Fees	73
Total (agree to Schedule V, line 19, column 8)		31,197

Kewanee Care Home
0056069
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	4,155
Auto Repairs		8,094
Mileage-Travel		1,297
Home Office Allocation		3,762
		17,308

Facility Name & ID Number Kewanee Care Home # 0056069 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. $ **23,707** 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. $ **148,631**
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. $ **4,767**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **3,961**
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. $ **n/a**

(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.