

		FOR BHF USE				

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

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

<p>I. IDPH License ID Number: <u>0047936</u></p> <p>Facility Name: <u>Rachuy House</u></p> <p>Address: <u>605 N Main Street</u> <u>Stockton</u> <u>61085</u> Number City Zip Code</p> <p>County: <u>Jo Daviess</u></p> <p>Telephone Number: <u>815-288-6691</u> Fax # <u>815-288-1636</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>7/1/06</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="padding-left: 20px;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="padding-left: 20px;"><input type="checkbox"/> Individual</td> <td style="padding-left: 20px;"><input type="checkbox"/> State</td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Trust</td> <td style="padding-left: 20px;"><input type="checkbox"/> Partnership</td> <td style="padding-left: 20px;"><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td style="padding-left: 20px;"><input type="checkbox"/> Corporation</td> <td style="padding-left: 20px;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Brenda Nailor</u> Telephone Number: <u>815-288-6691</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p style="text-align: center;"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/19</u> to <u>6/30/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. </p> <p style="text-align: center;"> Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. </p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Brenda Nailor</u> (Title) <u>Assistant Director of Finance</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # () </td> </tr> </table> <p style="text-align: center; font-weight: bold;"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Brenda Nailor</u> (Title) <u>Assistant Director of Finance</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																												

Facility Name & ID Number Rachuy House

0047936 Report Period Beginning: 7/1/19 Ending: 6/30/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,725			4,725	13
14	TOTALS	4,725			4,725	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.30%

D. How many bed reserve days during this year were paid by the Department?
150 (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)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/1/06 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/20 Fiscal Year: 06/30/20

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

Facility Name & ID Number Rachuy House # 0047936 Report Period Beginning: 7/1/19 Ending: 6/30/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	47,268		1,487	48,755		48,755		48,755		1
2	Food Purchase		38,077		38,077		38,077		38,077		2
3	Housekeeping	28,361	7,184	3,098	38,643		38,643		38,643		3
4	Laundry	9,454			9,454		9,454		9,454		4
5	Heat and Other Utilities			5,021	5,021		5,021	12,303	17,324		5
6	Maintenance	2,677	6,555	1,149	10,381		10,381	14,173	24,554		6
7	Other (specify):*										7
8	TOTAL General Services	87,760	51,816	10,755	150,331		150,331	26,476	176,807		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	173,016	6,028	2,620	181,664		181,664		181,664		10
10a	Therapy										10a
11	Activities	13,468	3,067		16,535		16,535		16,535		11
12	Social Services										12
13	CNA Training	6,734			6,734		6,734		6,734		13
14	Program Transportation			6,160	6,160		6,160		6,160		14
15	Other (specify):* Client Advocate		1,498		1,498		1,498		1,498		15
16	TOTAL Health Care and Programs	193,218	10,593	8,780	212,591		212,591		212,591		16
	C. General Administration										
17	Administrative	85,365		232,820	318,185		318,185		318,185		17
18	Directors Fees										18
19	Professional Services							21,319	21,319		19
20	Dues, Fees, Subscriptions & Promotions			2,290	2,290		2,290		2,290		20
21	Clerical & General Office Expenses		3,532	5,953	9,485		9,485	1,592	11,077		21
22	Employee Benefits & Payroll Taxes			41,016	41,016		41,016		41,016		22
23	Inservice Training & Education			2,622	2,622		2,622		2,622		23
24	Travel and Seminar			4,008	4,008		4,008		4,008		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			1,504	1,504		1,504	2,961	4,465		26
27	Other (specify):*										27
28	TOTAL General Administration	85,365	3,532	290,213	379,110		379,110	25,872	404,982		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	366,343	65,941	309,748	742,032		742,032	52,348	794,380		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

Rachuy House

#0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,763	18,763		18,763	22,373	41,136			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			104	104		104		104			32
33	Real Estate Taxes			(4)	(4)		(4)		(4)			33
34	Rent-Facility & Grounds			1,759	1,759		1,759		1,759			34
35	Rent-Equipment & Vehicles			17	17		17		17			35
36	Other (specify):*											36
37	TOTAL Ownership			20,639	20,639		20,639	22,373	43,012			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,611	38,611		38,611		38,611			42
43	Other (specify):* JDRS DT EXP			156,588	156,588		156,588		156,588			43
44	TOTAL Special Cost Centers			195,199	195,199		195,199		195,199			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	366,343	65,941	525,586	957,870		957,870	74,721	1,032,591			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 Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

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

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

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

Rachuy House

ID# 0047936

Report Period Beginning: 7/1/19

Ending: 6/30/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	12,303	0	0	0	0	0	0	0	0	0	12,303	5
6	Maintenance	0	14,173	0	0	0	0	0	0	0	0	0	14,173	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	26,476	0	0	0	0	0	0	0	0	0	26,476	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,319	0	0	0	0	0	0	0	0	0	21,319	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	1,592	0	0	0	0	0	0	0	0	0	1,592	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,961	0	0	0	0	0	0	0	0	0	2,961	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	25,872	0	0	0	0	0	0	0	0	0	25,872	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	52,348	0	0	0	0	0	0	0	0	0	52,348	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	22,373	0	0	0	0	0	0	0	0	0	22,373	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	22,373	0	0	0	0	0	0	0	0	0	22,373	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	74,721	0	0	0	0	0	0	0	0	0	74,721	45

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
Kreider Services, Inc.	100	Ashton Terrace Group Home	Ashton			
Kreider Services, Inc.	100	Boyd, Division, Wasson Group Homes	Amboy			
Kreider Services, Inc.	100	Franklin Grove, Ottawa, First St Group Homes	Franklin Grove/Dixon			
Kreider Services, Inc.	100	New Main Group Home	Dixon			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	3 Housekeeping	\$	JDRS	100.00%	\$		1
2	V	5 Utilities		JDRS	100.00%	12,303	12,303	2
3	V	6 Maintenance		JDRS	100.00%	14,173	14,173	3
4	V	19 Professional Services		JDRS	100.00%	21,319	21,319	4
5	V	20 License and Fees		JDRS	100.00%			5
6	V	21 General Office		JDRS	100.00%	1,592	1,592	6
7	V	26 Insurance-Property		JDRS	100.00%	2,961	2,961	7
8	V	30 Depreciation		JDRS	100.00%	22,373	22,373	8
9	V	43 Residual Receipts Payback		JDRS	100.00%			9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			74,721	\$ * 74,721	14

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

Facility Name & ID Number

Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rachuy House # 0047936 Report Period Beginning: 7/1/19 Ending: 6/30/20

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											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 Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending: 6/30/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Kreider Services, Inc.
 Street Address 500 Anchor Road
 City / State / Zip Code Dixon, IL 61021
 Phone Number (815-288-6691
 Fax Number (815-288-1636

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	Ln 17 Col 3	Central Office Costs	# of Clients	35	35	\$ 4,813,573	\$ 1,988,842		\$ 229,174	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,813,573	\$ 1,988,842		\$ 229,174	25

Facility Name & ID Number

Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

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		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						\$	\$			\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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

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

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

Facility Name & ID Number **Rachuy House**

0047936

Report Period Beginning: **7/1/19**

Ending:

6/30/20

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.

\$ **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.)

\$ **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **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.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	 	8
	2016	 	9
	2017	 	10
	2018	 	11
	2019	 	12

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 Rachuy House COUNTY Jo Daviess

FACILITY IDPH LICENSE NUMBER 0047936

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

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 _____ 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 Rachuy House

0047936 Report Period Beginning:

7/1/19 Ending:

6/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,445 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 1

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

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

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

Empty lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Building, 1992, \$22,545. Row 2: (blank). Row 3: TOTALS, \$22,545.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1993	\$ 281,986	\$ 4,518	26	\$ 4,518	\$	\$ 281,986	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Parking Lot		1993	11,782		20			11,782	9
10	Heating & A/C		1993	14,525		20			14,525	10
11	Sprinkler System		1993	4,841		20			4,841	11
12	Cabinets		1993	7,665		20			7,665	12
13	Carpeting		2001	4,321		10			4,321	13
14	Painting		2001	1,650	83	20	83		1,595	14
15	Painting		2001	1,650	83	20	83		1,582	15
16	Kick Plates/Door Stops		2001	133	7	20	7		127	16
17	Painting		2001	1,600	80	20	80		1,526	17
18	Roof		2002	16,500	825	20	825		15,056	18
19	Carpeting		2002	6,590		10			6,590	19
20	Tile Flooring		2003	1,278		10			1,278	20
21	architecture costs for 448 sq ft add'n in FY07-Schematic		2004	2,500	62	40	62		1,031	21
22	architecture costs for 448 sq ft add'n in FY07-Const Doc		2004	4,175	104	40	104		1,566	22
23	architecture costs for 448 sq ft add'n in FY07-Const Admin		2005	3,325	83	40	83		1,247	23
24	architecture costs for 448 sq ft add'n in FY07-Change Order		2005	175	4	40	4		64	24
25	Kitchen Addition		2007	153,915	3,848	40	3,848		50,023	25
26	New Cabinets		2008	4,023	268	15	268		3,465	26
27	Replacement windows		2011	35,790	2,386	15	2,386		21,673	27
28	Bath #1, southeast tub & Shower - Pumbing		2014	1,702	170	10	170		1,063	28
29	Bath #1, southeast tub & Shower - Painting		2014	400	40	10	40		250	29
30	Bath #1, southeast tub & Shower - Materials		2014	1,506	151	10	151		944	30
31	Bath #1, southeast tub & Shower - Tile Work		2014	2,861	286	10	286		1,787	31
32	Bath #1, southeast tub & Shower - Labor		2014	2,490	249	10	249		1,556	32
33	Carpet hallway & Closet		2015	1,130	38	5	38		1,130	33
34	Remodel NorthWest Bathroom - this includes Plumbing/parts/		2015	12,664	1,266	10	1,266		7,282	34
35	labor of \$1549.48, Shower/Floor tiles of \$5288.80, Painting of \$385,									35
36	dumpster of \$175, Contractor labor/mater of \$5265.34									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 Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	North East Bathroom Tile floor - includes removal of existing,	2016	\$ 1,487	\$ 149	10	\$ 149	\$	\$ 706	37
38	prep floor and Installation and grout of new tile floor.								38
39	Total Remodel of South West Bathroom. This includes new	2016	14,177	1,418	10	1,418		5,907	39
40	walls, plumbing, fixtures, tub toilet and all labor/materials								40
41	2-Ton Furnaces	2017	9,000	600	15	600		2,050	41
42	Generator - 38RCL Auto Standby (not complete - no depre FY18)	2019	24,475	4,895	5	4,895		8,974	42
43	Laminate Flooring	2019	1,010	202	5	202		269	43
44	AO Smith Water Heater	2020	6,700	558	10	558		558	44
45	Laminate Flooring - Bedroom	2020	535	71	5	71		71	45
46	Laminate Flooring - Bedroom	2020	213	28	5	28		28	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 638,774	\$ 22,472		\$ 22,472	\$	\$ 464,518	70

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

Facility Name & ID Number Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

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	\$ 56,935	\$ 2,193	\$ 2,193	\$ (0)	10	\$ 46,419	71
72	Current Year Purchases	6,302	341	341		10	341	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 63,237	\$ 2,534	\$ 2,534	\$ (0)		\$ 46,760	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	Residential Transport	2011 Ford 14 Passenger Van	2018	\$ 5,000	\$ 1,250	\$ 1,250	\$	4	\$ 2,188	76
77										77
78										78
79										79
80	TOTALS			\$ 5,000	\$ 1,250	\$ 1,250	\$		\$ 2,188	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)	\$ 729,556	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,256	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,256	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 513,466	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	Corporate Equipment		6,432		87
88	Corporate Vehicles		5,578		88
89	Corporate Leasehold		2,870		89
90					90
91	TOTALS	\$	14,880	\$	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 Rachuy House

0047936

Report Period Beginning: 7/1/19

Ending: 6/30/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>50</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		2,590		2,590
4	Clinical Wages (b)		4,144		4,144
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,734	\$	\$ 6,734
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,734		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/20

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (111,187)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (111,187)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 160,742	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 160,742	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(271,929)	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)	\$ (271,929)	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)	\$ (111,187)	24 *

* This must agree with page 17, line 47.

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

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 599,658	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 599,658	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	142,939	10
11	CNA Training Reimbursements	3,106	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 146,045	23
D. Non-Operating Revenue			
24	Contributions	3,714	24
25	Interest and Other Investment Income***	1,265	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,979	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Med Appts/JDRS Fee</u>	9,980	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 760,662	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	176,807	31
32	Health Care	212,591	32
33	General Administration	404,982	33
B. Capital Expense			
34	Ownership	43,012	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,611	36
D. Other Expenses (specify):			
37	<u>JDRS DT EXP</u>	156,588	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,032,591	40
41	Income before Income Taxes (line 30 minus line 40)**	(271,929)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (271,929)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rachuy House

0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	950	1,056	28,977	27.44	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	936	1,040	13,468	12.95	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,285	3,650	47,268	12.95	15
16	Dishwashers					16
17	Maintenance Workers	170	189	2,677	14.16	17
18	Housekeepers	1,971	2,190	28,361	12.95	18
19	Laundry	657	730	9,454	12.95	19
20	Administrator					20
21	Assistant Administrator	3,501	3,890	85,365	21.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,839	4,266	75,957	17.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	5,199	5,777	74,816	12.95	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,508	22,788	\$ 366,343 *	\$ 16.08	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 1,487		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	262		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Behavior Specialist</u>	1,196		46
47	<u>Physician</u>			47
48	<u>Psychiatrist</u>	1,174		48
49	TOTAL (lines 35 - 48)	\$ 4,119		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
R. Heiderscheit	Manager		\$ 31,837	Workers' Compensation Insurance	\$ 13,238	IDPH License Fee	\$		
R. Crain	Supervisor		53,528	Unemployment Compensation Insurance	876	Advertising: Employee Recruitment	1,311		
				FICA Taxes	14,087	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	6,615	Patient Background Checks			
				Employee Meals		Subscriptions	33		
				Illinois Municipal Retirement Fund (IMRF)*		Dues			
				403b Pension Plan	3,426	Misc. Fees	668		
				Tuition Reimbursement	22	DOT Drug Screen/Physicals	205		
				Christmas Gift/Party	955	Late Fee - Provider Tax			
				Physical Exam	1,797	Less: Public Relations Expense ()			
				Accrued Vacation Pay		Non-allowable advertising ()			
				Trf to Capital - Maintenance		Yellow page advertising ()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,365	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 41,016		\$ 2,217			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Allocation of Mgt & General			\$ 229,174				Out-of-State Travel	\$	
Consultant Expense - Legal									
Consultant Expense - Other			3,646				In-State Travel	4,008	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 232,820	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
				\$			\$ 4,008		
C. Professional Services									
Vendor/Payee	Type								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rachuy House# 0047936

Report Period Beginning:

7/1/19

Ending:

6/30/20**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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ We do not track Line 10 Col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES 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. \$ 38,611
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? N/A
- (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? N/A 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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Clifton Larson Allen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.