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.

I. IDPH License ID Number: 0053637

Facility Name: Rushville Nursing Rehab Ctr

Address: 135 South Morgan St (Number) Rushville (City) 62681 (Zip Code)

County: Schuyler

Telephone Number: (217) 322-3201 **Fax #** (217) 322-2828

HFS ID Number:

Date of Initial License for Current Owners: 7/31/2015

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: Joshua S. Banach **Telephone Number:** (847) 628 - 8784
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 1/1/20 to 12/31/20 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)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Denise A Leonard, CPA, Partner
(Firm Name & Address) Plante & Moran, PLLC, 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 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	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	3,263	3,315	6,325	12,903	8
9	SNF/PED					9
10	ICF	9,133	1,247		10,380	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,396	4,562	6,325	23,283	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.26%

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)
N/A

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 [X]

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 07/31/15

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/31/15 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 5,648

Medicare Intermediary National Government Services, Inc.

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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	194,970	28,767	7,202	230,939		230,939	76	231,015			1
2	Food Purchase		156,219		156,219		156,219	56	156,275			2
3	Housekeeping	75,996	18,219		94,215		94,215	665	94,880			3
4	Laundry	27,328	13,012	1,585	41,925		41,925		41,925			4
5	Heat and Other Utilities			90,953	90,953		90,953	(3,300)	87,653			5
6	Maintenance	90,964	75,249	5,549	171,762		171,762	9,769	181,531			6
7	Other (specify):*			14,737	14,737		14,737	2,004	16,741			7
8	**TOTAL General Services**	389,258	291,466	120,026	800,750		800,750	9,270	810,020			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,572,923	84,428	8,054	1,665,405		1,665,405	(77)	1,665,328			10
10a	Therapy	25,389		641,291	666,680		666,680		666,680			10a
11	Activities	26,708	4,109		30,817		30,817		30,817			11
12	Social Services	85,072		3,706	88,778		88,778		88,778			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,710,092	88,537	655,451	2,454,080		2,454,080	(77)	2,454,003			16
	C. General Administration											
17	Administrative	143,109			143,109		143,109	9,527	152,636			17
18	Directors Fees											18
19	Professional Services			205,635	205,635		205,635	(119,922)	85,713			19
20	Dues, Fees, Subscriptions & Promotions			27,952	27,952		27,952	(5,409)	22,543			20
21	Clerical & General Office Expenses	66,984	44,767	20,912	132,663		132,663	15,864	148,527			21
22	Employee Benefits & Payroll Taxes			341,758	341,758		341,758		341,758			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,257	2,257		2,257	202	2,459			24
25	Other Admin. Staff Transportation			45,753	45,753		45,753	(15,106)	30,647			25
26	Insurance-Prop.Liab.Malpractice			135,319	135,319		135,319	(11,860)	123,459			26
27	Other (specify):*			17,473	17,473		17,473	(3,451)	14,022			27
28	**TOTAL General Administration**	210,093	44,767	797,059	1,051,919		1,051,919	(130,155)	921,764			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,309,443	424,770	1,572,536	4,306,749		4,306,749	(120,962)	4,185,787			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 Rushville Nursing Rehab Ctr #0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			6,862	6,862		6,862	69,508	76,370			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,228	2,228		2,228	68,644	70,872			32
33	Real Estate Taxes			38,415	38,415		38,415	2,552	40,967			33
34	Rent-Facility & Grounds			260,714	260,714		260,714	(260,714)				34
35	Rent-Equipment & Vehicles			17,015	17,015		17,015	139	17,154			35
36	Other (specify):*											36
37	**TOTAL Ownership**			325,234	325,234		325,234	(119,871)	205,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,137	195,502	197,639		197,639		197,639			39
40	Barber and Beauty Shops			72	72		72	(72)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,287	162,287		162,287		162,287			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,137	357,861	359,998		359,998	(72)	359,926			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,309,443	426,907	2,255,631	4,991,981		4,991,981	(240,905)	4,751,076			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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	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
5	Telephone, TV & Radio in Resident Rooms	(4,029)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,084)	30		9
10	Interest and Other Investment Income	(35)	32		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	(1,250)	27		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	(16,223)	27		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	(117,883)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,504)		$	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)	(86,402)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (86,402)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (240,906)		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

Rushville Nursing Rehab Ctr

ID# 0053637

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 328	06	1
2	Rushville HC Properties- Management Fees	(7,622)	17	2
3	Rushville HC Properties- Acct & Prof Fees	(11,156)	19	3
4	Rushville HC Properties- Misc. Admin Fees	(414)	21	4
5	Rushville HC Properties- Amortiation	(1,229)	31	5
6	Patient Clothing	(77)	10	6
7	Barber & Beauty Expense	(72)	40	7
8	Bank Charges	(1,002)	21	8
9	Collections Expense	(3,042)	21	9
10	Insurance Settlement Payment	(12,678)	26	10
11	Write off of Debt	(27,318)	21	11
12	Miscellaneous Income	(205)	21	12
13	PAC Dues	(6,650)	20	13
14	Capitalized Van	(15,487)	25	14
15	Capitalized R&M	(3,000)	06	15
16	PPP Consulting	(1,800)	19	16
17	Non-Allowable Expense	(26,458)	21	17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(117,882)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	76	0	0	0	0	0	0	0	0	76	1
2	Food Purchase	0	0	56	0	0	0	0	0	0	0	0	56	2
3	Housekeeping	0	0	665	0	0	0	0	0	0	0	0	665	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	729	0	0	0	0	0	0	0	0	729	5
6	Maintenance	(2,672)	0	1,451	10,990	0	0	0	0	0	0	0	9,770	6
7	Other (specify):*	0	0	0	2,004	0	0	0	0	0	0	0	2,004	7
8	**TOTAL General Services**	(2,672)	0	2,977	12,995	0	0	0	0	0	0	0	13,299	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	(77)	0	0	0	0	0	0	0	0	0	0	(77)	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**	(77)	0	0	0	0	0	0	0	0	0	0	(77)	16
	C. General Administration													
17	Administrative	(7,622)	7,622	0	9,527	0	0	0	0	0	0	0	9,527	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,956)	11,156	(118,122)	0	0	0	0	0	0	0	0	(119,922)	19
20	Fees, Subscriptions & Promotions	(6,650)	0	1,241	0	0	0	0	0	0	0	0	(5,409)	20
21	Clerical & General Office Expenses	(58,439)	414	6,532	67,357	0	0	0	0	0	0	0	15,864	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	202	0	0	0	0	0	0	0	0	202	24
25	Other Admin. Staff Transportation	(15,487)	0	381	0	0	0	0	0	0	0	0	(15,106)	25
26	Insurance-Prop.Liab.Malpractice	(12,678)	0	818	0	0	0	0	0	0	0	0	(11,860)	26
27	Other (specify):*	0	0	0	14,022	0	0	0	0	0	0	0	14,022	27
28	**TOTAL General Administration**	(113,832)	19,192	(108,948)	90,906	0	0	0	0	0	0	0	(112,682)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,581)	19,192	(105,971)	103,901	0	0	0	0	0	0	0	(99,460)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(15,084)	83,309	1,283	0	0	0	0	0	0	0	0	69,508	30
31	Amortization of Pre-Op. & Org.	(1,229)	1,229	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	64,095	4,584	0	0	0	0	0	0	0	0	68,679	32
33	Real Estate Taxes	0	0	2,552	0	0	0	0	0	0	0	0	2,552	33
34	Rent-Facility & Grounds	0	(260,714)	0	0	0	0	0	0	0	0	0	(260,714)	34
35	Rent-Equipment & Vehicles	0	0	139	0	0	0	0	0	0	0	0	139	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,313)	(112,081)	8,558	0	0	0	0	0	0	0	0	(119,836)	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	(72)	0	0	0	0	0	0	0	0	0	0	(72)	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**	(72)	0	0	0	0	0	0	0	0	0	0	(72)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(132,966)	(92,889)	(97,413)	103,901	0	0	0	0	0	0	0	(219,367)	45

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - 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	34	Rent	$ 260,714	Rushville Healthcare Properties, LLC	100.00%	$	$ (260,714)	1
2	V	33	RE Taxes	38,415	Rushville Healthcare Properties, LLC	100.00%	38,415		2
3	V	17	Management Fees		Rushville Healthcare Properties, LLC	100.00%	7,622	7,622	3
4	V	19	Accounting/Professional Fees		Rushville Healthcare Properties, LLC	100.00%	11,156	11,156	4
5	V	21	Misc. Admin Expenses		Rushville Healthcare Properties, LLC	100.00%	414	414	5
6	V	30	Depreciation		Rushville Healthcare Properties, LLC	100.00%	83,309	83,309	6
7	V	31	Amortization		Rushville Healthcare Properties, LLC	100.00%	1,229	1,229	7
8	V	32	Interest Expense		Rushville Healthcare Properties, LLC	100.00%	64,095	64,095	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 299,129			$ 206,240	$ * (92,889)	14

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Sherwin Ray	60%	BEECHER MANOR NURSING AND REHABIL	BEECHER	Ex Care Consulting	Evanston, IL	Home Office	1
2	Atied Associates, LLC	40%	BURBANK REHABILITATION CENTER	BURBANK	Ex . Care Clinical	Evanston, IL	Administrative	2
3			CHATEAU NURSING AND REHABILITATIO	WILLOWBROOK	2201 Main Street	Evanston, IL	Bldg. Company	3
4			COUNTRYSIDE NURSING AND REHABILITA	DOLTON	CCS VEBA	Evanston, IL	Health Insurance	4
5			GRASMERE PLACE, LLC	CHICAGO	Vent Lease	Evanston, IL	Vent. Rental	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			LAKEWOOD NURSING & REHABILITATION	PLAINFIELD	Rushville HC	Rushville, IL	Bldg. Company	7
8			LEMONT NURSING AND REHABILITATION	LEMONT	Properties LLC			8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH C	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITA	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER,	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REH	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CEN	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, IN	CAMP POINT				24
25			WESTMONT MANOR HEALTH & REHAB CE	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	01	Dietary	$	Extended Care Consulting	100.00%	$ 76	$ 76	15
16	V	02	Food		Extended Care Consulting	100.00%	56	56	16
17	V	03	Housekeeping		Extended Care Consulting	100.00%	665	665	17
18	V	05	Utilities		Extended Care Consulting	100.00%	729	729	18
19	V	06	Maintenance		Extended Care Consulting	100.00%	1,451	1,451	19
20	V	17	Administrative		Extended Care Consulting	100.00%	0		20
21	V	19	Professional Fees		Extended Care Consulting	100.00%	2,966	2,966	21
22	V	20	Dues and Subscriptions		Extended Care Consulting	100.00%	1,241	1,241	22
23	V	21	Office and Clerical		Extended Care Consulting	100.00%	6,532	6,532	23
24	V	24	Seminar and Travel		Extended Care Consulting	100.00%	202	202	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting	100.00%	381	381	25
26	V	26	Insurance		Extended Care Consulting	100.00%	818	818	26
27	V	30	Depreciation		Extended Care Consulting	100.00%	1,283	1,283	27
28	V	32	Interest		Extended Care Consulting	100.00%	4,584	4,584	28
29	V	33	Real Estate Taxes		Extended Care Consulting	100.00%	2,552	2,552	29
30	V	34	Rent - Building		Extended Care Consulting	100.00%	0		30
31	V	35	Rent - Equipment		Extended Care Consulting	100.00%	139	139	31
32	V	19	Consulting Fees	121,088	Extended Care Consulting	100.00%		(121,088)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,088			$ 23,675	$ * (97,413)	39

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	06	Maintenance Salaries	$	Extended Care Consulting	100.00%	$ 10,990	$ 10,990	15
16	V	06	Maintenance (Direct)		Extended Care Consulting	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting	100.00%	2,004	2,004	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting	100.00%			20
21	V	17	Administrative Salaries		Extended Care Consulting	100.00%	9,527	9,527	21
22	V	21	Office and Clerical Salaries		Extended Care Consulting	100.00%	67,357	67,357	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting	100.00%	14,022	14,022	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting				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			$			$ 103,901	$ * 103,901	39

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	22	Employee Benefits	$ 159,751	CCS VEBA	100.00%	$ 159,751	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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			$ 159,751			$ 159,751	$ *	39

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Adam Vales	Relative	Clerical	0.00%	See Attached	0.8	2.00%	Alloc Salary	$ 1,420	22-07	1
2	Sherwin Ray	Owner	Administrative	60.00%	See Attached	4.95	12.38%	Salary	24,760	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,180		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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
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					$	$		$	25

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 491-9565

	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	01	Dietary	Resident Days	1,219,947	36	$ 3,992	$	23,283	$ 76	1
2	02	Food	Resident Days	1,219,947	36	2,910		23,283	56	2
3	03	Housekeeping	Resident Days	1,219,947	36	34,856		23,283	665	3
4	05	Utilities	Resident Days	1,219,947	36	38,173		23,283	729	4
5	06	Maintenance	Resident Days	1,219,947	36	76,040		23,283	1,451	5
6	17	Administrative	Resident Days	1,219,947	36			23,283		6
7	19	Professional Fees	Resident Days	1,219,947	36	155,408		23,283	2,966	7
8	20	Dues and Subscriptions	Resident Days	1,219,947	36	64,998		23,283	1,241	8
9	21	Office and Clerical	Resident Days	1,219,947	36	342,251		23,283	6,532	9
10	24	Seminar and Travel	Resident Days	1,219,947	36	10,602		23,283	202	10
11	25	Other Staff Admin. Trans.	Resident Days	1,219,947	36	19,988		23,283	381	11
12	26	Insurance	Resident Days	1,219,947	36	42,836		23,283	818	12
13	30	Depreciation	Resident Days	1,219,947	36	67,209		23,283	1,283	13
14	32	Interest	Resident Days	1,219,947	36	240,208		23,283	4,584	14
15	33	Real Estate Taxes	Resident Days	1,219,947	36	133,701		23,283	2,552	15
16	34	Rent - Building	Resident Days	1,219,947	36			23,283		16
17	35	Rent - Equipment	Resident Days	1,219,947	36	7,304		23,283	139	17
18	19	Consulting Fees	Resident Days	1,219,947	36			23,283		18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,240,476	$		$ 23,675	25

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 491-9565

	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	06	Maintenance Salaries	Resident Days	1,219,947	36	$ 575,856	$ 575,856	23,283	$ 10,990	1
2	06	Maintenance (Direct)								2
3	07	Emp. Ben. - Gen. Serv.	Resident Days	1,219,947	36	105,021		23,283	2,004	3
4	07	Emp. Ben. - Gen. Serv. (Direct)								4
5	12	Admission (Direct)								5
6	15	Emp. Ben. - Nursing (Direct)								6
7	17	Administrative Salaries	Resident Days	1,219,947	36	499,202	499,202	23,283	9,527	7
8	21	Office and Clerical Salaries	Resident Days	1,219,947	36	3,529,267	3,529,267	23,283	67,357	8
9	21	Office and Clerical (Direct)								9
10	27	Emp. Ben. - Gen. Admin.	Resident Days	1,219,947	36	734,685		23,283	14,022	10
11	27	Emp. Ben. - Gen. Admin. (Direct)								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					$ 5,444,030	$ 4,604,325		$ 103,900	25

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: CCS VEBA
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 491-9565

	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	22	Employee Benefits	Direct Allocation	8,032,049		$ 8,032,049	$	159,751	$ 159,751	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					$ 8,032,049	$		$ 159,751	25

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Heartland Bank		X	Mortgage			$	$ 966,850			$ 46,046	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated From ECC		X								4,584	6
7	Atied Associates		X	Working Capital				3,250				7
8	Altitude Investments		X	Working Capital				225,000			18,049	8
9	TOTAL Facility Related						$	$ 1,195,100			$ 68,679	9
	B. Non-Facility Related*											
10	Interest Income		X								(35)	10
11	Miscellaneous Interest		X								2,228	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,193	14
15	TOTALS (line 9+line14)						$	$ 1,195,100			$ 70,872	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.**	$ 40,908	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.)		$ 41,238	2
3. Under or (over) accrual (line 2 minus line 1).		$ 330	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,629	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.)**		$ 8	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.		$ 40,967	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	39,610	8
	2016	39,611	9
	2017	38,957	10
	2018	38,960	11
	2019	38,694	12

2020 Accrual: $38,694 X 1.05 = $40,629

Allocated From ECC: $2,552

	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 Rushville Nursing Rehab Ctr COUNTY Schuyler

FACILITY IDPH LICENSE NUMBER 0053637

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628 - 8784 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-30-451-008	Long Term Care Facility	$ 296.52	$ 296.52
2.	08-30-379-004	Long Term Care Facility	$ 57.56	$ 57.56
3.	08-30-451-006	Long Term Care Facility	$ 438.28	$ 438.28
4.	08-30-377-011	Long Term Care Facility	$ 70.56	$ 70.56
5.	08-30-379-003	Long Term Care Facility	$ 189.64	$ 189.64
6.	08-30-377-012	Long Term Care Facility	$ 390.30	$ 390.30
7.	08-30-451-007	Long Term Care Facility	$ 1,586.86	$ 1,586.86
8.	08-30-379-001	Long Term Care Facility	$ 173.34	$ 173.34
9.	08-30-379-002	Long Term Care Facility	$ 210.04	$ 210.04
10.	See Supplemental Schedule	See Supplemental Schedule	$ 232,444.05	$ 37,833.08
		TOTALS	$ 235,857.15	$ 41,246.18

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? X 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rushville Nursing Rehab Ctr COUNTY Schuyler

FACILITY IDPH LICENSE NUMBER 0053637

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628 - 8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-30-376-044	Long Term Care Facility	$ 243.60	$ 243.60
2.	08-30-377-009	Long Term Care Facility	$ 34,751.40	$ 34,751.40
3.	08-30-377-010	Long Term Care Facility	$ 286.36	$ 286.36
4.	Extended Care Consulting, LLC	Home Office Allocation	$ 197,162.69	$ 2,551.72
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 232,444.05	$ 37,833.08

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? X 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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,354 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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).

None

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 171,881	1
2	Allocated From ECC			10,613	2
3	TOTALS			$ 182,494	3

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	99		2015	1966	$ 1,428,751	$	40	$ 35,719	$ 35,719	$ 214,313	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Architecture Planning			2015	3,220		20	161	161	966	9
10	Window Coverings - Blinds (Resident Rooms)			2016	3,054		20	153	153	764	10
11	Roofing			2018	24,650		20	1,233	1,233	3,698	11
12	Repair/Installation of HVAC System/AC Unit (Whole Facility)			2020	3,000		20	150	150	150	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	Financial Statement Depreciation- Rushville Nursing & Rehab Center					6,862			(6,862)		28
29	Financial Statement Depreciation- Rushville HC Properties					83,309			(83,309)		29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Related Party Allocations								38
39									39
40	Dyer Building Allocation	2007	4,580	101	40	101		1,370	40
41	Allocated From ECC/2201 Main	2002	14,625	375	40	375		6,859	41
42									42
43									43
44	Allocated From ECC/2201 Main	2002	12,081		20			12,081	44
45	Allocated From ECC/2201 Main	2003	14,237		20			14,237	45
46	Allocated From ECC/2201 Main	2005	707		20			707	46
47	Allocated From ECC/2201 Main	2009	128	6	20	6		77	47
48	Allocated From ECC/2201 Main	2014	1,225	61	20	61		429	48
49	Allocated From ECC/2201 Main	2015	201	10	20	10		130	49
50	Allocated From ECC/2201 Main	2016	795	40	20	40		199	50
51	Allocated From ECC/2201 Main	2017	1,379	69	20	69		276	51
52	Allocated From ECC/2201 Main	2018	632	32	20	32		95	52
53	Allocated From ECC/2201 Main	2019	238	12	20	12		24	53
54	Allocated From ECC/2201 Main	2020	64	3	20	3		3	54
55									55
56	Allocated From ECC	2007	88	4	20	4		61	56
57	Allocated From ECC	2009	52	3	20	3		32	57
58	Allocated From ECC	2010	515	26	20	26		283	58
59	Allocated From ECC	2011	185	9	20	9		93	59
60	Allocated From ECC	2012	61	3	20	3		27	60
61	Allocated From ECC	2014	846	42	20	42		296	61
62	Allocated From ECC	2016	1,015	51	20	51		254	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	70

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12B, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12D, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12E, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12F, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12G, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12H, Carried Forward		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,516,329	$ 91,018		$ 38,262	$ (52,756)	$ 257,423	34

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 16,104	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Attached Schedule	382,891	435	32,475	32,040		254,360	74
75	TOTALS	$ 398,995	$ 435	$ 32,475	$ 32,040		$ 254,360	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	Chevy 3500 Diamond Coach	2020	$ 12,678	$	$ 2,536	$ 2,536	5	$ 2,536	76
77	Facility	Accessible Van	2020	15,487		3,097	3,097	5	3,097	77
78	Allocated From ECC		2014	486					486	78
79										79
80	TOTALS			$ 28,651	$	$ 5,633	$ 5,633		$ 6,119	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)	$ 2,126,469	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,453	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 76,369	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,084)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 517,901	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					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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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: $ 17,154 Description: $1,717 Dish Machine; $800 Laundry Machine; $14,498 Copier/Printer/Office Equip; $139 Allocated-ECC
(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.

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	hrs	$	3,827	$ 287,041	$	3,827	$ 287,041	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		635	47,655		635	47,655	2
3	Licensed Recreational Therapist	V10A	hrs			0				3
4	Licensed Physical Therapist	V10A	hrs		4,088	306,595		4,088	306,595	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	25,389					25,389	8
9	Pharmacy	V39	# of prescrpts				177,321		177,321	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					18,181		18,181	12
13	Other (specify): BILLABLE SUPPLIES	V39					2,137		2,137	13
14	TOTAL			$ 25,389	8,551	$ 641,291	$ 197,639	8,551	$ 864,319	14

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,335,627	$ 1,401,426	1
2	Cash-Patient Deposits	21,113	21,113	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,183,720	2,183,720	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,556	41,556	6
7	Other Prepaid Expenses	6,451	6,451	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	117	19,508	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,588,584	$ 3,673,773	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		171,881	13
14	Buildings, at Historical Cost		1,259,903	14
15	Leasehold Improvements, at Historical Cost	24,650	193,498	15
16	Equipment, at Historical Cost	32,164	352,559	16
17	Accumulated Depreciation (book methods)	(20,591)	(662,694)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	37,538	37,538	21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 73,761	$ 1,352,685	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,662,345	$ 5,026,458	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 703,798	$ 703,798	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,936	21,936	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,427	89,427	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,582	2,582	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,629	40,629	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	983,949	1,021,487	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,842,321	$ 1,879,859	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,250	228,250	39
40	Mortgage Payable		966,850	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,078,227	1,078,227	43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,081,477	$ 2,273,327	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,923,798	$ 4,153,186	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 738,547	$ 873,273	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,662,345	$ 5,026,458	48

*(See instructions.)

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,565,656)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,565,656)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,304,203	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)**	$ 2,304,203	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)**	$ 738,547	24	*

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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 6,648,797	1
2	Discounts and Allowances for all Levels	(2,267,935)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,380,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,903,866	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,903,866	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	271,939	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,870	19
20	Radiology and X-Ray	1,290	20
21	Other Medical Services	5,515	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 292,614	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		718,807	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 718,807	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,296,184	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	800,750	31
32	Health Care	2,454,080	32
33	General Administration	1,051,919	33
	B. Capital Expense		
34	Ownership	325,234	34
	C. Ancillary Expense		
35	Special Cost Centers	197,711	35
36	Provider Participation Fee	162,287	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,991,981	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,304,203	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,304,203	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,002,118	44
45	Private Pay - Net Inpatient Revenue	996,626	45
46	Medicare - Net Inpatient Revenue	1,493,424	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	73,726	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(185,032)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,380,862	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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 Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	1,942	2,154	$ 97,523	$ 45.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,035	17,541	608,317	34.68	3
4	Licensed Practical Nurses	9,056	9,777	242,639	24.82	4
5	CNAs & Orderlies	37,985	41,632	624,444	15.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,566	1,810	25,389	14.03	8
9	Activity Director					9
10	Activity Assistants	2,579	2,730	26,708	9.78	10
11	Social Service Workers	2,914	3,250	84,175	25.90	11
12	Dietician					12
13	Food Service Supervisor	2,206	2,347	32,573	13.88	13
14	Head Cook	13,735	15,021	162,397	10.81	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,319	5,959	90,964	15.26	17
18	Housekeepers	6,873	7,611	75,996	9.99	18
19	Laundry	2,504	2,739	27,328	9.98	19
20	Administrator	2,416	2,651	143,109	53.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,681	6,723	66,984	9.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	66	82	897	10.94	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,877	122,027	$ 2,309,443 *	$ 18.93	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	109	$ 7,202	V01-03	35
36	Medical Director	Monthly Fees	2,400	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	5,616	V10-03	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	37	3,298	V12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant	3	408	V12-03	47
48					48
49	TOTAL (lines 35 - 48)	149	$ 18,924		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

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keesha Abernathy	Administrator	0.00%	$ 118,349
Sherwin Ray	Administrative	60.00%	24,760
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,109

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Plante Moran	Accounting Services	$ 27,295
Ability Networks	Data Processing/Billing	7,332
Matrix Care	Data Processing/Software	11,154
Propay	Payroll Processing	13,147
National Data Care Corp	Resident Fund Processing	1,017
Personnel Planners	Unemployment Consulting	792
IIT/Sourcetech	IT Consulting	551
Legat Architects	Architecture Services	18,163
Sher LLP	PPP Consulting (Adjusted)	1,800
Neal Gerber & Eisenberg	Legal Services	177
Ronald L Cournaya	Cost Reporting	3,120
See Supplemental Page 21		121,088
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 205,635

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,463
Unemployment Compensation Insurance	9,625
FICA Taxes	163,363
Employee Health Insurance	121,954
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	7,072
Holiday Expense	4,281
TOTAL (agree to Schedule V, line 22, col.8)	$ 341,758

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	10,485
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	7,318
Licenses and Fees	1,509
Allocatecd From ECC	1,241
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,543

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,257
Allocatecd From ECC	202
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,459

**See instructions.

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Consulting	Consulting/Bookkeeping	$ 121,088

TOTAL (agree to Schedule V, line 19, column 3) $ 121,088
(For legal fee disclosure, see page 39 of instructions)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

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

Description	Line #	Amount
		$

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)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

**See instructions.

Facility Name & ID Number Rushville Nursing Rehab Ctr # 0053637 Report Period Beginning: 1/1/20 Ending: 12/31/20

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? **Yes**
If YES, give association name and amount. **Healthcare Council of IL $13,301**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,785** Line **10-2**

(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. **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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **162,287**
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? **No** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%-Ln1**
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? **No**
Firm Name: **N/A**

(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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.