FOR BHF USE

LL1

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: 0056366

Facility Name: Sullivan Rehab Hlth Care Ctr

Address: 11 Hawthorne Lane (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4327 Fax # (217) 728-2263

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1986

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Mark Petersen
	(Title)	Chief Executive Officer
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone)	( ) Fax # ( )

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,455	2,836	2,873	24,164	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,455	2,836	2,873	24,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.82%

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)
Meals on Wheels

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/3/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/3/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 123 and days of care provided 2,621

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	194,780	30,413	1,159	226,352		226,352	6,415	232,767			1
2	Food Purchase		185,583		185,583		185,583	(1,323)	184,260			2
3	Housekeeping	159,944	42,847		202,791		202,791	124	202,915			3
4	Laundry		10,304	17,160	27,464		27,464		27,464			4
5	Heat and Other Utilities			175,112	175,112		175,112	438	175,550			5
6	Maintenance	84,305	20,105	24,394	128,804		128,804	3,852	132,656			6
7	Other (specify):*											7
8	**TOTAL General Services**	439,029	289,252	217,825	946,106		946,106	9,506	955,612			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,330,422	127,620	21,674	1,479,716		1,479,716	1,656	1,481,372			10
10a	Therapy			404,991	404,991		404,991		404,991			10a
11	Activities	52,685	23,197		75,882		75,882	(8,289)	67,593			11
12	Social Services	92,815			92,815		92,815		92,815			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,475,922	150,817	438,665	2,065,404		2,065,404	(6,633)	2,058,771			16
	C. General Administration											
17	Administrative	80,004		253,200	333,204		333,204	(217,526)	115,678			17
18	Directors Fees											18
19	Professional Services			17,019	17,019		17,019	305,852	322,871			19
20	Dues, Fees, Subscriptions & Promotions			4,753	4,753		4,753	3,284	8,037			20
21	Clerical & General Office Expenses	35,686	2,978	5,061	43,725		43,725	39,610	83,335			21
22	Employee Benefits & Payroll Taxes			225,417	225,417		225,417	11,110	236,527			22
23	Inservice Training & Education							66	66			23
24	Travel and Seminar							20	20			24
25	Other Admin. Staff Transportation			8,134	8,134		8,134	4,596	12,730			25
26	Insurance-Prop.Liab.Malpractice			70,451	70,451		70,451	700	71,151			26
27	Other (specify):*											27
28	**TOTAL General Administration**	115,690	2,978	584,035	702,703		702,703	147,712	850,415			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,030,641	443,047	1,240,525	3,714,213		3,714,213	150,585	3,864,798			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 Sullivan Rehab Hlth Care Ctr #0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,028	8,028		8,028	71,802	79,830			30
31	Amortization of Pre-Op. & Org.							174,946	174,946			31
32	Interest			12,485	12,485		12,485	699,955	712,440			32
33	Real Estate Taxes			54,224	54,224		54,224	253	54,477			33
34	Rent-Facility & Grounds			580,741	580,741		580,741	(580,741)				34
35	Rent-Equipment & Vehicles			71,957	71,957		71,957	106,669	178,626			35
36	Other (specify):*											36
37	TOTAL Ownership			727,435	727,435		727,435	472,884	1,200,319			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,601		77,601		77,601		77,601			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,574	196,574		196,574		196,574			42
43	Other (specify):*		600	95,289	95,889		95,889	(95,889)				43
44	TOTAL Special Cost Centers		78,201	291,863	370,064		370,064	(95,889)	274,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,030,641	521,248	2,259,823	4,811,712		4,811,712	527,580	5,339,292			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 Sullivan Rehab Hlth Care Ctr **#** 0056366 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 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	(1,323)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,647)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	326	30		9
10	Interest and Other Investment Income	(84)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(198)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(40,548)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,000)	43		24
25	Fund Raising, Advertising and Promotional	(901)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,330)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (110,705)		$	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)	638,285	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 638,285		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 527,580		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

STATE OF ILLINOIS

Sullivan Rehab Hlth Care Ctr

ID# 0056366

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (8,541)	43	1
2	X-Rays-Part A	(9,242)	43	2
3	Offset Miscellaneous Transportation Revenue	(8,289)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(164)	21	4
5	Pet Expense	(663)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(5,282)	10	6
7	Special Events	(149)	43	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**	(32,330)		49

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 6,414	$ 6,414	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	124	124	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	438	438	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,852	3,852	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	6,011	6,011	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	253,200	Petersen Health Care Management, Inc.	100.00%	35,674	(217,526)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	21,072	21,072	12
13	V								13
14	Total			$ 253,200			$ 73,585	$ * (179,615)	14

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 3,284	$ 3,284	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,774	39,774	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,918	10,918	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	66	66	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	21	21	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,596	4,596	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	700	700	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	6,493	6,493	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	316	316	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	253	253	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,329	2,329	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			$			$ 68,750	$ * 68,750	39

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care II, LLC	100.00%	$	$	15
16	V	2	Food		Petersen Health Care II, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Care II, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Care II, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Care II, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Care II, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	927	927	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Care II, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Care II, LLC	100.00%	284,780	284,780	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Care II, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	192	192	28
29	V	23	Inservice Training & Education		Petersen Health Care II, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Care II, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Care II, LLC	100.00%	424	424	33
34	V	31	Amortization		Petersen Health Care II, LLC	100.00%			34
35	V	32	Interest		Petersen Health Care II, LLC	100.00%	6,579	6,579	35
36	V	33	Real Estate Taxes		Petersen Health Care II, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	104,340	104,340	38
39	Total			$			$ 397,242	$ * 397,242	39

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Sullivan Land, LLC	100.00%	$	$	15
16	V	19	Professional Services	$	Sullivan Land, LLC	100.00%			16
17	V	21	Equipment		Sullivan Land, LLC	100.00%			17
18	V	26	Insurance-Property		Sullivan Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Sullivan Land, LLC	100.00%			19
20	V	30	Depreciation		Sullivan Land, LLC	100.00%	64,559	64,559	20
21	V	31	Amortization		Sullivan Land, LLC	100.00%	174,946	174,946	21
22	V	32	Interest		Sullivan Land, LLC	100.00%	693,144	693,144	22
23	V	33	Real Estate Taxes		Sullivan Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	580,741	Sullivan Land, LLC	100.00%		(580,741)	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			$ 580,741			$ 932,649	$ * 351,908	39

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

STATE OF ILLINOIS

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

STATE OF ILLINOIS

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,286,694	75	$ 341,556	$ 398,718	24,164	$ 6,414	1
2	2	Food	Resident Days	1,286,694	75	0	0	24,164	0	2
3	3	Housekeeping	Resident Days	1,286,694	75	6,605	3,056	24,164	124	3
4	5	Utilities	Resident Days	1,286,694	75	23,319	0	24,164	438	4
5	6	Maintenance	Resident Days	1,286,694	75	205,135	187,746	24,164	3,852	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,286,694	75	0	0	24,164	0	6
7	9	Medical Director	Resident Days	1,286,694	75	0	0	24,164	0	7
8	10	Nursing and Medical Records	Resident Days	1,286,694	75	320,054	736,064	24,164	6,011	8
9	10A	Therapy	Resident Days	1,286,694	75	0	0	24,164	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,286,694	75	0	0	24,164	0	10
11	17	Administrative	Resident Days	1,286,694	75	1,899,564	7,673,667	24,164	35,674	11
12	19	Professional Services	Resident Days	1,286,694	75	1,122,027	0	24,164	21,072	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,286,694	75	174,864	0	24,164	3,284	13
14	21	Clerical and General Office	Resident Days	1,286,694	75	2,117,879	2,195,755	24,164	39,774	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,286,694	75	581,392	0	24,164	10,918	15
16	23	Inservice Training & Education	Resident Days	1,286,694	75	3,515	0	24,164	66	16
17	24	Travel and Seminar	Resident Days	1,286,694	75	1,093	0	24,164	21	17
18	25	Other Admin. Staff Transport.	Resident Days	1,286,694	75	244,707	0	24,164	4,596	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,286,694	75	37,296	0	24,164	700	19
20	30	Depreciation	Resident Days	1,286,694	75	345,756	0	24,164	6,493	20
21	31	Amortization	Resident Days	1,286,694	75	0	0	24,164	0	21
22	32	Interest	Resident Days	1,286,694	75	16,848	0	24,164	316	22
23	33	Real Estate Taxes	Resident Days	1,286,694	75	13,448	0	24,164	253	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,286,694	75	124,022	0	24,164	2,329	24
25	TOTALS					$ 7,579,080	$ 11,195,006		$ 142,335	25

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	92,563	5	$	$	14,411	$	1
2	2	Food	Resident Days	92,563	5			14,411		2
3	3	Housekeeping	Resident Days	92,563	5			14,411		3
4	4	Laundry	Resident Days	92,563	5			14,411		4
5	5	Utilities	Resident Days	92,563	5			14,411		5
6	6	Maintenance	Resident Days	92,563	5			14,411		6
7	7	Mgmt. Allocation of Benefits	Resident Days	92,563	5			14,411		7
8	10	Nursing and Medical Records	Resident Days	92,563	5	5,954		14,411	927	8
9	15	Mgmt. Allocation of Benefits	Resident Days	92,563	5			14,411		9
10	17	Administrative	Resident Days	92,563	5			14,411		10
11	19	Professional Services	Resident Days	92,563	5	1,829,164		14,411	284,780	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	92,563	5			14,411		12
13	21	Clerical and General Office	Resident Days	92,563	5			14,411		13
14	22	Employee Benefits & Payroll	Resident Days	92,563	5	1,233		14,411	192	14
15	23	Inservice Training & Education	Resident Days	92,563	5			14,411		15
16	24	Travel and Seminar	Resident Days	92,563	5			14,411		16
17	25	Other Admin. Staff Transport.	Resident Days	92,563	5			14,411		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	92,563	5			14,411		18
19	30	Depreciation	Resident Days	92,563	5	2,726		14,411	424	19
20	31	Amortization	Resident Days	92,563	5			14,411		20
21	32	Interest	Resident Days	92,563	5	42,259		14,411	6,579	21
22	33	Real Estate Taxes	Resident Days	92,563	5			14,411		22
23	34	Rent-Facility and Grounds	Resident Days	92,563	5			14,411		23
24	35	Rent-Equipment & Vehicles	Resident Days	92,563	5	670,184		14,411	104,340	24
25	TOTALS					$ 2,551,520	$		$ 397,242	25

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Huntington Bank		X	Mortgage	Varies	2/1/17	$ 1,743,600	$ Paid			$ 11,570	1
2	Sector		X	Mortgage	Varies	4/1/2020	9,316,840	9,316,840	3/31/23	Varies	693,144	2
3	Dodge		X	Vehicle	Varies	6/29/20	48,780	44,310	6/28/25	Varies	915	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 11,109,220	$ 9,361,150			$ 705,629	9
	B. Non-Facility Related*											
10								Interest Income Offset			(84)	10
11								Home Office Allocation-PHCM			316	11
12								Home Office Allocation-PHC II			6,579	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 6,811	14
15	TOTALS (line 9+line14)						$ 11,109,220	$ 9,361,150			$ 712,440	15

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

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

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

Facility Name & ID Number: Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	48,856	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.)	$	50,617	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,761	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	52,463	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 253 **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.	$	54,477	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	48,788	8
2016	49,592	9
2017	47,313	10
2018	47,066	11
2019	50,617	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

Line	Description		Line
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 Sullivan Health Care Center COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

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

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	08-08-11-400-004	Long-Term Care Facility	$ 49,970.00	$ 49,970.00
2.	08-08-12-300-073	Long-Term Care Facility	$ 646.74	$ 646.74
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,616.74	$ 50,616.74

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 466,523 2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 174,946 4. Dates Incurred: 2020

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	339,095	2003	$ 100,001	1
2					2
3	TOTALS	339,095		$ 100,001	3

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	123		2003	1975	$ 1,560,545	$	39	$ 40,014	$ 40,014	$ 711,576	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			2004	4,808		25	192	192	3,120	9
10	Fire Alarms			2004	1,524		25	61	61	966	10
11	Doors			2004	3,067		5			3,067	11
12	Smoke Alarms			2004	1,227		7			1,227	12
13	Land Improvements			2006	7,262		15	484	484	7,018	13
14	New Roof			2006	28,308		25	1,132	1,132	16,414	14
15	Kitchen Remodel			2006	22,241		25	890	890	12,905	15
16	Landscaping			2006	2,434		15	162	162	2,349	16
17	Sidewalks			2007	1,785		15	120	120	1,620	17
18	Sprinkler System			2008	14,839		25	594	594	7,425	18
19	Back Flow			2009	5,470		7			5,470	19
20	Water Heater			2009	2,983		5			2,983	20
21	Roof Repairs			2011	2,536		7			2,536	21
22	Nurses Station			2013	17,449		15	1,164	1,164	8,730	22
23	Tiling of Shower			2014	8,225		15	548	548	3,836	23
24	Water Heater-LA			2014	3,493		7	499	499	3,244	24
25	Roof Repairs			2014	2,800		7	400	400	2,600	25
26	Roof Replacement			2014	6,764		25	271	271	1,762	26
27	Roof Replacement			2014	12,600		25	504	504	3,276	27
28	Fencing			2014	3,395		15	226	226	1,469	28
29	Grease Trap Repair			2014	5,222		7	746	746	4,849	29
30	Water Heater			2014	3,375		7	482	482	3,133	30
31	A/C Unit - Roof Top			2014	8,384		15	559	559	3,634	31
32	Furnace			2016	9,734		15	648	648	2,916	32
33	Window Framing, Gutter Replace, Privacy Fence, Roof Repair			2016	26,314		15	1,754	1,754	7,893	33
34	Roof Replacement			2018	157,173		25	6,286	6,286	15,715	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 Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Line Repair	2019	$ 2,799	$	7	$ 400	$ 400	$ 600	37
38	Plumbing Repair	2020	5,378		7	384	384	384	38
39	Water Heaters (2)	2020	17,985		7	1,285	1,285	1,285	39
40	Roof Replacement	2020	86,133		25	1,723	1,723	1,723	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	Land Improvements Booked			557			(557)		57
58	Building Booked			40,014			(40,014)		58
59	Building Improvement Booked			20,463			(20,463)		59
60									60
61	2020-Home Office Allocation-Building Improvements		12,181			292	292		61
62	2020-Home Office Allocation-Land Improvements		1,222			77	77		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,049,655	$ 61,034		$ 61,897	$ 863	$ 845,725	70

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

Facility Name & ID Number: Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 49,775	$ 5,460	$ 5,982	$ 522	5-10 yrs.	$ 29,312	71
72	Current Year Purchases	7,342	402	525	123	7 yrs.	525	72
73	Fully Depreciated Assets	653,036					653,036	73
74	Home Office Allocation			6,548	6,548			74
75	TOTALS	$ 710,153	$ 5,862	$ 13,055	$ 7,193		$ 682,873	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	2003 Ford	2003	$ 31,116	$	$	$		$ 31,116	76
77	Facility	2018 Dodge Pro Van	2020	48,780	5,691	4,878	(813)	5 yrs.	4,878	77
78										78
79										79
80	TOTALS			$ 79,896	$ 5,691	$ 4,878	$ (813)		$ 35,994	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)	$ 2,939,705	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,587	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 79,830	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,243	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,564,592	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 178,626 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Sullivan Rehab Hlth Care Ctr
0056366
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 64,640
Dishwasher	701
Copier	6,616
Home Office Allocation	106,669
	178,626

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	12,071	$ 181,068	$	12,071	$ 181,068	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,200	47,998		3,200	47,998	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,721	175,809		11,721	175,809	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				77,601		77,601	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(3)			8	116		8	116	12
13	Other (specify):									13
14	TOTAL			$	27,000	$ 404,991	$ 77,601	27,000	$ 482,592	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 Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (202,973)	$ (202,973)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 58,255)	2,519,342	2,519,342	3
4	Supply Inventory (priced at Cost)	13,122	13,122	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,751	28,751	6
7	Other Prepaid Expenses	1,149,804	1,149,804	7
8	Accounts Receivable (owners or related parties)		16,188	8
9	Other(specify): Employee Education Loans	3,517	3,517	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,511,563	$ 3,527,751	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,001	13
14	Buildings, at Historical Cost		1,572,726	14
15	Leasehold Improvements, at Historical Cost	109,496	476,929	15
16	Equipment, at Historical Cost	84,301	790,049	16
17	Accumulated Depreciation (book methods)	(39,144)	(1,564,592)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		291,577	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	65,383	779,386	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	418,385	418,385	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 638,421	$ 2,864,461	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,149,984	$ 6,392,212	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,013,042	$ 1,013,042	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,024	106,024	30
31	Accrued Taxes Payable (excluding real estate taxes)	116,514	116,514	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,463	52,463	32
33	Accrued Interest Payable		111,731	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	1,067	1,067	36
37	Accrued Management Fees	66	66	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,289,176	$ 1,400,907	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,310	44,310	39
40	Mortgage Payable		9,316,840	40
41	Bonds Payable			41
42	Deferred Compensation	26,242	26,242	42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,049,342	1,034,762	43
44	Loan Payable-MCAD Adv. & SBA PPP	1,131,600	1,131,600	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,251,494	$ 11,553,754	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,540,670	$ 12,954,661	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 609,314	$ (6,562,449)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,149,984	$ 6,392,212	48

*(See instructions.)

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (738,693)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	366,908	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (371,785)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	981,099	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)**	$ 981,099	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)**	$ 609,314	24 *

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,219,313	1
2	Discounts and Allowances for all Levels	(961,071)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,258,242	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	651,116	6
7	Oxygen	1,177	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 652,293	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	1,323	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,083	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,240	20
21	Other Medical Services	24,992	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 150,638	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	84	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 84	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Revenue	8,289	28
28a	Miscellaneous & COVID Stimulus Revenue	723,265	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 731,554	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,792,811	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	946,106	31
32	Health Care	2,065,404	32
33	General Administration	702,703	33
	B. Capital Expense		
34	Ownership	727,435	34
	C. Ancillary Expense		
35	Special Cost Centers	173,490	35
36	Provider Participation Fee	196,574	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,811,712	40
41	**Income before Income Taxes (line 30 minus line 40)****	981,099	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 981,099	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,835,528	44
45	Private Pay - Net Inpatient Revenue	516,475	45
46	Medicare - Net Inpatient Revenue	867,498	46
47	Other-(specify) Insurance Net Inpatient Revenue	38,741	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,258,242	49

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

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

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

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

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,603	1,603	$ 64,155	$ 40.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,449	2,607	75,638	29.01	3
4	Licensed Practical Nurses	17,177	17,663	434,384	24.59	4
5	CNAs & Orderlies	46,772	47,367	628,122	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	27,335	13.14	9
10	Activity Assistants					10
11	Social Service Workers	4,274	4,370	92,815	21.24	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	45,367	21.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,186	13,554	149,413	11.02	15
16	Dishwashers					16
17	Maintenance Workers	4,863	5,070	84,305	16.63	17
18	Housekeepers	14,546	14,673	159,944	10.90	18
19	Laundry					19
20	Administrator	2,080	2,080	80,004	38.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	35,686	17.16	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,195	1,209	39,109	32.35	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,660	1,660	36,977	22.28	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	3,462	3,542	77,387	21.85	33
34	TOTAL (lines 1 - 33)	119,427	121,638	$ 2,030,641 *	$ 16.69	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	19	$ 1,159	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,881	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	13,428	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	19	$ 34,468		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	12	365	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	12	$ 365		53

Sullivan Rehab Hlth Care Ctr
0056366
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,462	1,462	52,037	35.59
Transportation	2,000	2,080	25,350	12.19
TOTAL	3,462	3,542	77,387	

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 253,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 253,200

C. Professional Services

Vendor/Payee	Type	Amount
Lindsay, Pickett, Postel	Legal Fees-6/11/20	$ 5,000
Mediacom	Computer Services	1,590
Ability Network	Computer Services	9,395
Illinois Secretary of State	Legal Filing Fees	155
Moultrie County Recorder	Legal Filing Fees	67
Sector Bank	Title Lien Search-July 2020	812
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 17,019

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,861
Unemployment Compensation Insurance	24,379
FICA Taxes	145,880
Employee Health Insurance	7,511
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,125
Home Office Allocation	11,110
Employee Retirement	665
Administrator Benefits	15,996
TOTAL (agree to Schedule V, line 22, col.8)	$ 236,527

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 19)	
Patient Background Checks 76	2,275
Miscellaneous Licenses & Permits	488
Home Office Allocation	3,284
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,037

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	20
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20

**See instructions.

Sullivan Rehab Hlth Care Ctr
0056366
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		17,019
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	371
Duane Morris	Legal	518
Lexis Nexis	Legal	10
Livingston, Barger, Brant, Schroeder	Legal	20
Miller, Hall, Triggs	Legal	64
Miscellaneous	Legal	24
SB2	Legal	192
SmithAmundsen LLC	Legal	1,185
Sorling Northrup	Legal	338
Applegate & Thorne	Legal	10,813
Baker Tilly Virchow Krause LLP	Legal	1,018
Boyle Brasher LLC	Legal	1,122
Bureau Veritas Technical Assessment	Legal	622
Chapman and Keller	Legal	43,902
CliftonLarsonAllen	Legal	2,615
Duane Morris	Legal	88,967
Elias, Meginnes, Seghetti	Legal	91
Illinois Secretary of State	Legal	125
Lashly & Baer	Legal	1,231
Livingston, Barger, Brandt, Schroeder	Legal	4,491
Moore, Susler, McNutt, Wrigley	Legal	1,492
Saul Ewing Arntstein & Lehr	Legal	336
Sector	Legal	9,579
Sedgwick Claims Management	Legal	29,326
SmithAmundsen	Legal	5,080
Sorling Northrup	Legal	1,309
SPI Corporate Solutions	Legal	14,338
Stanley, Lande and Hunter	Legal	496
CliftonLarsonAllen	Accounting	2,829
Ginoli & Co.	Accounting	1,543
Ability Network	Computer Services	3,781
Allscripts	Computer Services	597
AOD Matrix Care	Computer Services	6,641
AT&T	Computer Services	7
ATS	Computer Services	362
CCH	Computer Services	21
Charter Communications	Computer Services	33
Citrix Systems	Computer Services	113
Comcast	Computer Services	39
ITSavvy	Computer Services	175
Kemper Technology	Computer Services	863
Miscellaneous	Computer Services	167
Pearl Technology	Computer Services	156
Stratus Networks	Computer Services	686
TR Professional	Computer Services	15
David Budde	Other Prof Fees	15
DJ Howard and Associates	Other Prof Fees	29
Getzler Henrich & Associates	Other Prof Fees	117
LRI Consulting Services	Other Prof Fees	114
McQuellon Consulting	Other Prof Fees	72
Miscellaneous	Other Prof Fees	153
Optimizer	Other Prof Fees	61
Registered Agent Solutions	Other Prof Fees	34
RSM McGladrey	Other Prof Fees	375
SB2	Other Prof Fees	479
Sedgwick CMS	Other Prof Fees	646
Tarver Program Consultants	Other Prof Fees	89
D.J. Howard & Associates	Other Prof Fees	1,168
Creative Health Capital	Other Prof Fees	11,591
Getzler Henrich & Associates	Other Prof Fees	10,935
Health Dimensions	Other Prof Fees	1,557
Mohr & Kerr Engineering and Land Surveying	Other Prof Fees	29,250
SB2	Other Prof Fees	934
Scott Commuication Solutions	Other Prof Fees	2,335
Sedgwick Claims Management	Other Prof Fees	8,195
Total (agree to Schedule V, line 19, column 8)		322,871

Sullivan Rehab Hlth Care Ctr
0056366
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	4,424
Auto Repairs		3,710
Mileage-Travel		-
Home Office Allocation		4,596
		12,730

Facility Name & ID Number Sullivan Rehab Hlth Care Ctr # 0056366 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,371** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **196,574**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,323**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **8,289**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees.