		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0052258

Facility Name: Toulon Rehab Health Care Ctr

Address: Hwy 17 East Box 249 (Number) Toulon (City) 61483 (Zip Code)

County: Stark

Telephone Number: (309) 286-2631 **Fax #** (309) 286-4851

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2005

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,640	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	456	5,364	2,562	8,382	8
9	SNF/PED					9
10	ICF	19,710			19,710	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,166	5,364	2,562	28,092	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.59%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 82 and days of care provided 2,219

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 Toulon Rehab Health Care Ctr # 0052258 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	196,848	33,955		230,803		230,803	7,480	238,283			1
2	Food Purchase		211,920		211,920		211,920	(4,560)	207,360			2
3	Housekeeping	121,422	40,072		161,494		161,494	145	161,639			3
4	Laundry	71,865	10,478		82,343		82,343		82,343			4
5	Heat and Other Utilities			84,544	84,544		84,544	511	85,055			5
6	Maintenance	62,356	7,246	44,833	114,435		114,435	5,030	119,465			6
7	Other (specify):*											7
8	TOTAL General Services	452,491	303,671	129,377	885,539		885,539	8,606	894,145			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,672,987	135,105	30,816	1,838,908		1,838,908	7,994	1,846,902			10
10a	Therapy			229,646	229,646		229,646		229,646			10a
11	Activities	69,933	48		69,981		69,981	(3,168)	66,813			11
12	Social Services	29,825			29,825		29,825		29,825			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,772,745	135,153	272,462	2,180,360		2,180,360	4,826	2,185,186			16
	C. General Administration											
17	Administrative	99,000		281,800	380,800		380,800	(240,201)	140,599			17
18	Directors Fees											18
19	Professional Services			9,043	9,043		9,043	68,494	77,537			19
20	Dues, Fees, Subscriptions & Promotions			2,608	2,608		2,608	3,499	6,107			20
21	Clerical & General Office Expenses	32,733	3,980	10,457	47,170		47,170	46,362	93,532			21
22	Employee Benefits & Payroll Taxes			268,776	268,776		268,776	12,732	281,508			22
23	Inservice Training & Education							77	77			23
24	Travel and Seminar							24	24			24
25	Other Admin. Staff Transportation			11,341	11,341		11,341	5,359	16,700			25
26	Insurance-Prop.Liab.Malpractice			2,584	2,584		2,584	53,785	56,369			26
27	Other (specify):*											27
28	TOTAL General Administration	131,733	3,980	586,609	722,322		722,322	(49,869)	672,453			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,356,969	442,804	988,448	3,788,221		3,788,221	(36,437)	3,751,784			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 Toulon Rehab Health Care Ctr #0052258 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			22,320	22,320		22,320	155,699	178,019			30
31	Amortization of Pre-Op. & Org.							7,565	7,565			31
32	Interest							122,129	122,129			32
33	Real Estate Taxes							128,149	128,149			33
34	Rent-Facility & Grounds			383,437	383,437		383,437	(383,437)				34
35	Rent-Equipment & Vehicles			41,078	41,078		41,078	146,779	187,857			35
36	Other (specify):*											36
37	TOTAL Ownership			446,835	446,835		446,835	176,884	623,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,476		51,476		51,476		51,476			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			205,989	205,989		205,989		205,989			42
43	Other (specify):*	35,214	136	65,751	101,101		101,101	(101,101)				43
44	TOTAL Special Cost Centers	35,214	51,612	271,740	358,566		358,566	(101,101)	257,465			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,392,183	494,416	1,707,023	4,593,622		4,593,622	39,346	4,632,968			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 Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,560)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,304)	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	(2,022)	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(370)	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	(23,111)	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	(20,000)	43		24
25	Fund Raising, Advertising and Promotional	(836)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(924)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(57,170)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,319)		$	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)	155,665	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 155,665		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 39,346		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

Toulon Rehab Health Care Ctr

ID# 0052258

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (6,166)	43	1
2	X-Rays-Part A	(4,757)	43	2
3	Disallowed Special Events	342	43	3
4	Offset Miscellaneous Nursing Supplies Revenue	(3,039)	10	4
5	Offset Miscellaneous Cable TV Revenue	(3,675)	43	5
6	Offset Transportation Revenue	(3,168)	11	6
7	Pet Expense	(1,145)	43	7
8	Offset Chamber of Commerce Dues	(330)	20	8
9	Disallowed Marketing Salaries	(35,214)	43	9
10	Offset Miscellaneous Office Supplies Revenue	(18)	10	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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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**	(57,170)		49

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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%	$ 7,480	$ 7,480	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%	145	145	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	511	511	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	4,492	4,492	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%	7,009	7,009	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	281,800	Petersen Health Care Management, Inc.	100.00%	41,599	(240,201)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	24,571	24,571	12
13	V								13
14	Total			$ 281,800			$ 85,807	$ * (195,993)	14

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 3,829	$ 3,829	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	46,380	46,380	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	12,732	12,732	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	77	77	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	24	24	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	5,359	5,359	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	817	817	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	7,572	7,572	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%	369	369	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	295	295	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,716	2,716	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			$			$ 80,170	$ * 80,170	39

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Management Company, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Management Company, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Management Company, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Management Company, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Management Company, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Management Company, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Management Company, LLC	100.00%	4,024	4,024	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Management Company, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Management Company, LLC	100.00%	37,223	37,223	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Management Company, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Management Company, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Management Company, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Management Company, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Management Company, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Management Company, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Management Company, LLC	100.00%	2,804	2,804	33
34	V	31	Amortization		Petersen Management Company, LLC	100.00%	0		34
35	V	32	Interest		Petersen Management Company, LLC	100.00%	439	439	35
36	V	33	Real Estate Taxes		Petersen Management Company, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Management Company, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Management Company, LLC	100.00%	144,063	144,063	38
39	Total			$			$ 188,553	$ * 188,553	39

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Petersen 27, LLC	100.00%	$ 538	$ 538	15
16	V	19	Professional Services		Petersen 27, LLC	100.00%	6,700	6,700	16
17	V	21	Equipment		Petersen 27, LLC	100.00%			17
18	V	26	Insurance-Property		Petersen 27, LLC	100.00%	7,446	7,446	18
19	V	26	Insurance-Liability		Petersen 27, LLC	100.00%	18,290	18,290	19
20	V	26	Insurance-Mortgage Insurance		Petersen 27, LLC	100.00%	27,232	27,232	20
21	V	30	Depreciation		Petersen 27, LLC	100.00%	147,345	147,345	21
22	V	31	Amortization		Petersen 27, LLC	100.00%	7,565	7,565	22
23	V	32	Interest	445	Petersen 27, LLC	100.00%	121,788	121,343	23
24	V	33	Real Estate Taxes		Petersen 27, LLC	100.00%	127,854	127,854	24
25	V	34	Rent-Income and Grounds	383,437	Petersen 27, LLC	100.00%		(383,437)	25
26	V	43	Service Charges		Petersen 27, LLC	100.00%	2,059	2,059	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			$ 383,882			$ 466,817	$ * 82,935	39

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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 Toulon Rehab Health Care Ctr # 0052258 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 Toulon Rehab Health Care Ctr # 0052258 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 Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	$ 341,562	$ 398,718	28,092	$ 7,480	1
2	2	Food	Resident Days	1,282,791	75	0	0	28,092	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	28,092	145	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	28,092	511	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	28,092	4,492	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	28,092	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	28,092	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	28,092	7,009	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	28,092	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	28,092	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	28,092	41,599	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	28,092	24,571	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	28,092	3,829	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	28,092	46,380	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	28,092	12,732	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	28,092	77	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	28,092	24	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	28,092	5,359	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	28,092	817	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	28,092	7,572	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	28,092	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	28,092	369	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	28,092	295	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	28,092	2,716	24
25	TOTALS					$ 7,579,077	$ 11,195,006		$ 165,977	25

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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 Management Company, 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	130,685	6	$	$	28,092	$	1
2	2	Food	Resident Days	130,685	6			28,092		2
3	3	Housekeeping	Resident Days	130,685	6			28,092		3
4	4	Laundry	Resident Days	130,685	6			28,092		4
5	5	Utilities	Resident Days	130,685	6			28,092		5
6	6	Maintenance	Resident Days	130,685	6			28,092		6
7	7	Mgmt. Allocation of Benefits	Resident Days	130,685	6			28,092		7
8	10	Nursing and Medical Records	Resident Days	130,685	6	18,718		28,092	4,024	8
9	15	Mgmt. Allocation of Benefits	Resident Days	130,685	6			28,092		9
10	17	Administrative	Resident Days	130,685	6			28,092		10
11	19	Professional Services	Resident Days	130,685	6	173,161		28,092	37,223	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	130,685	6			28,092		12
13	21	Clerical and General Office	Resident Days	130,685	6			28,092		13
14	22	Employee Benefits & Payroll	Resident Days	130,685	6			28,092		14
15	23	Inservice Training & Education	Resident Days	130,685	6			28,092		15
16	24	Travel and Seminar	Resident Days	130,685	6			28,092		16
17	25	Other Admin. Staff Transport.	Resident Days	130,685	6			28,092		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	130,685	6			28,092		18
19	30	Depreciation	Resident Days	130,685	6	13,046		28,092	2,804	19
20	31	Amortization	Resident Days	130,685	6			28,092		20
21	32	Interest	Resident Days	130,685	6	2,043		28,092	439	21
22	33	Real Estate Taxes	Resident Days	130,685	6			28,092		22
23	34	Rent-Facility and Grounds	Resident Days	130,685	6			28,092		23
24	35	Rent-Equipment & Vehicles	Resident Days	130,685	6	670,184		28,092	144,063	24
25	TOTALS					$ 877,152	$		$ 188,553	25

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Huntington Bank		X	HUD Mortgage	Varies	5/1/13	5,272,000	$ 4,109,823	4/30/38	Varies	$ 121,788	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,272,000	$ 4,109,823			$ 121,788	9
	B. Non-Facility Related*											
10								Interest Income Offset			(467)	10
11								Home Office Allocation-PHCM			369	11
12								Home Office Allocation-PMC			439	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 341	14
15	TOTALS (line 9+line14)						$ 5,272,000	$ 4,109,823			$ 122,129	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 27,232 Line # 26

* 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 Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	127,896	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.)	$	127,062	2
3. Under or (over) accrual (line 2 minus line 1).	$	(834)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	128,688	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**		295	
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.	$	128,149	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	126,892	8
	2016	125,293	9
	2017	124,860	10
	2018	124,176	11
	2019	127,062	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Toulon Rehabilitation & Health Care Center COUNTY Stark

FACILITY IDPH LICENSE NUMBER 0052258

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-19-401-037	Long-Term Care Facility	$ 2,117.62	$ 2,117.62
2.	04-19-401-039	Long-Term Care Facility	$ 124,943.96	$ 124,943.96
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 127,061.58	$ 127,061.58

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 189,131 2. Number of Years Over Which it is Being Amortized: 25

3. Current Period Amortization: 7,565 4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	38,000	2005	$ 150,000	1
2					2
3	TOTALS	38,000		$ 150,000	3

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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	136		2005	1977	$ 3,371,115	$	30	$ 112,370	$ 112,370	$ 1,797,921	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking lot/sidewalks			2005	621,663		15			621,663	9
10	New Carpet			2005	9,194		10			9,194	10
11	Fire Suppression System			2005	9,750		10			9,750	11
12	Sidewalks			2006	10,292		15	686	686	10,061	12
13	Water Heater			2007	5,159		10			5,159	13
14	Fire/Door Alarms			2007	2,090		10			2,090	14
15	Water Heater			2009	3,900		5			3,900	15
16	Water Heater			2009	6,200		5			6,200	16
17	Remodeling of A,B,C wings			2009	12,950		15	864	864	9,936	17
18	A/C Unit			2010	4,200		15	280	280	2,940	18
19	Pipe Repair			2010	4,045		7			4,045	19
20	Sidewalk Repair			2012	4,100		15	274	274	2,329	20
21	Water Line Repair			2013	14,841		15	990	990	7,425	21
22	Water Heater			2013	3,801		7	265	265	3,801	22
23	Blacktop Resurfacing			2014	43,400		15	2,893	2,893	15,912	23
24	Nurse Call System			2014	4,276		7	611	611	3,972	24
25	Sidewalk Replacement			2014	4,100		15	273	273	1,775	25
26	Roof Repair			2015	4,535		7	648	648	3,564	26
27	Water Heater			2015	3,444		7	492	492	2,706	27
28	Tiling for Dining Room			2015	2,700		7	386	386	2,123	28
29	Water System Repair			2016	3,952		7	564	564	2,538	29
30	Furnace Repair			2016	2,645		7	378	378	1,701	30
31	Landscaping			2016	18,330		15	2,444	2,444	10,998	31
32	Blinds			2016	22,587		15	1,506	1,506	6,777	32
33	Nurses Station			2016	17,605		15	1,174	1,174	5,283	33
34	Carpet and Tiling-Therapy/Activity Room, Nurses Station			2016	68,762		15	4,584	4,584	20,628	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 Toulon Rehab Health Care Ctr # 0052258 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	C	2017	$ 6,348	$	15	$ 424	$ 424	$ 1,484	37
38	Security System and Smoke Detector Install	2017	7,510		7	1,072	1,072	3,752	38
39	Tiling for Therapy Room and Beauty Shop	2017	3,980		7	568	568	1,988	39
40	Nurses Station Installation	2017	65,106		15	4,340	4,340	15,190	40
41	Tiling for 4 Hallways, Shower Rooms, Alzheimer's Unit	2017	55,269		25	2,210	2,210	7,735	41
42	Water Heater-100 Gallon	2017	4,395		7	628	628	2,198	42
43	Roof Repairs	2017	40,558		15	2,704	2,704	9,464	43
44	Water Softener	2017	7,500		7	1,072	1,072	3,752	44
45	Water Heater-120 Gallon	2018	5,228		7	746	746	1,865	45
46	Furnace	2018	3,494		15	232	232	580	46
47	Sprinkler Repair	2019	4,275		7	612	612	918	47
48	Air Conditoner	2019	3,494		15	232	232	348	48
49	Water Heater	2019	8,415		7	1,202	1,202	1,803	49
50	Sprinkler Head Repair	2019	3,016		7	430	430	645	50
51	Water Line Repair	2019	2,700		7	386	386	579	51
52	Air Conditoners-Living Room, Laundry, Kitchen Areas	2019	14,845		15	990	990	1,485	52
53	Furnace	2019	3,494		15	232	232	348	53
54	Air Conditioner	2020	16,845		15	550	550	550	54
55	Water Heater	2020	7,516		7	537	537	537	55
56	Water Heater	2020	11,080		7	791	791	791	56
57	Boiler Mixing Valve Repair	2020	3,715		7	265	265	265	57
58	Water Heater Repair	2020	10,901		7	779	779	779	58
59	Water Pipe Repair	2020	2,540		7	181	181	181	59
60	Sprinkler Valve Repair	2020	8,105		7	579	579	579	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,579,965	$		$ 153,444	$ 153,444	$ 2,632,207	70

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,579,965	$		$ 153,444	$ 153,444	$ 2,632,207	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	Land Improvements Booked			3,853			(3,853)		24
25	Building Booked			112,371			(112,371)		25
26	Building Improvement Booked			40,507			(40,507)		26
27									27
28	2020-Home Office Allocation-Building Improvements		14,204			341	341		28
29	2020-Home Office Allocation-Land Improvements		1,425			90	90		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,595,594	$ 156,731		$ 153,875	$ (2,856)	$ 2,632,207	34

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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	$ 96,597	$ 8,214	$ 9,479	$ 1,265	5-10 yrs.	$ 62,728	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	951,610					951,610	73
74	Home Office Allocation			9,945	9,945			74
75	TOTALS	$ 1,048,207	$ 8,214	$ 19,424	$ 11,210		$ 1,014,338	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 Use	1998 Dodge Maxivan	2005	$ 17,500	$	$	$		$ 17,500	76
77	Facility Use	2016 Ford E150 Van	2017	23,600	4,720	4,720		5 yrs.	16,520	77
78										78
79										79
80	TOTALS			$ 41,100	$ 4,720	$ 4,720	$		$ 34,020	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)	$ 5,834,901	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 169,665	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,019	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,354	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,680,565	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 Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

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

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 187,857 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.

Toulon Rehab Health Care Ctr
0052258
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	$ 35,135
Dishwasher	701
Copier	5,242
Home Office Allocation	146,779
	187,857

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	4,851	$ 72,762	$	4,851	$ 72,762	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,628	39,427		2,628	39,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,830	117,457		7,830	117,457	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				51,476		51,476	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	15,309	$ 229,646	$ 51,476	15,309	$ 281,122	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 Toulon Rehab Health Care Ctr # 0052258 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	$ (14,479)	$ (14,479)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 87,174)	1,688,365	1,688,365	3
4	Supply Inventory (priced at Cost)	19,674	19,674	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,681	38,000	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		48,214	8
9	Other(specify): Employee Education Loans	5,383	5,383	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,722,624	$ 1,785,157	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		3,385,319	14
15	Leasehold Improvements, at Historical Cost	128,350	1,210,275	15
16	Equipment, at Historical Cost	64,399	1,089,307	16
17	Accumulated Depreciation (book methods)	(89,139)	(3,680,565)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		189,131	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(58,000)	20
21	Restricted Funds		251,453	21
22	Other Long-Term Assets (spe Goodwill	266,772	266,772	22
23	Other(specify): Intercompany Loans	1,777,849	1,845,854	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,148,231	$ 4,649,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,870,855	$ 6,434,703	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 878,055	$ 878,551	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,070	99,070	30
31	Accrued Taxes Payable (excluding real estate taxes)	137,413	137,413	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,688	32
33	Accrued Interest Payable		9,453	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	4,608	4,608	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,119,146	$ 1,257,783	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,109,823	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv Payment	2,000,000	2,000,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,000,000	$ 6,109,823	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,119,146	$ 7,367,606	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 751,709	$ (932,903)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,870,855	$ 6,434,703	48

***(See instructions.)**

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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**	$ (2,857,438)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	1,149,899	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,707,539)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,459,248	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)**	$ 2,459,248	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)**	$ 751,709	24 *

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

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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	$ 5,584,171	1
2	Discounts and Allowances for all Levels	(577,476)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,006,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	466,831	6
7	Oxygen	860	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 467,691	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,560	14
15	Telephone, Television and Radio	3,675	15
16	Rental of Facility Space		16
17	Sale of Drugs	98,363	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,336	20
21	Other Medical Services	33,743	21
22	Laundry	(3,052)	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 152,625	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Transportation Revenue**	3,168	28
28a	**Miscellaneous and COVID Stimulus Revenue**	1,422,669	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,425,837	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,052,870	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	885,539	31
32	Health Care	2,180,360	32
33	General Administration	722,322	33
	B. Capital Expense		
34	Ownership	446,835	34
	C. Ancillary Expense		
35	Special Cost Centers	152,577	35
36	Provider Participation Fee	205,989	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,593,622	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,459,248	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,459,248	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,122,189	44
45	Private Pay - Net Inpatient Revenue	852,236	45
46	Medicare - Net Inpatient Revenue	808,927	46
47	Other-(specify) **Insurance Net Inpatient Revenue**	223,343	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,006,695	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 Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,034	2,172	$ 67,750	$ 31.19	1
2	Assistant Director of Nursing	21	21	638	30.38	2
3	Registered Nurses	4,843	4,955	166,371	33.58	3
4	Licensed Practical Nurses	16,741	17,876	464,478	25.98	4
5	CNAs & Orderlies	51,530	53,022	796,396	15.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,038	2,070	28,796	13.91	9
10	Activity Assistants	1,343	1,356	13,787	10.17	10
11	Social Service Workers	2,047	2,193	29,825	13.60	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	43,272	20.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,234	14,749	153,576	10.41	15
16	Dishwashers					16
17	Maintenance Workers	3,991	4,079	62,356	15.29	17
18	Housekeepers	10,756	11,256	121,422	10.79	18
19	Laundry	6,943	7,341	71,865	9.79	19
20	Administrator	1,984	2,168	99,000	45.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,154	2,157	32,733	15.18	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	1,747	1,819	53,367	29.34	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	7,441	7,706	186,551	24.21	33
34	TOTAL (lines 1 - 33)	131,927	137,020	$ 2,392,183 *	$ 17.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,618	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	50	2,894	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)	50	$ 23,512		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	17	446	L10,C3	51
52	Certified Nurse Assistants/Aides	857	18,858	L10,C3	52
53	TOTAL (lines 50 - 52)	874	$ 19,304		53

Toulon Rehab Health Care Ctr
0052258
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	3,771	3,896	123,490	31.70
Transportation	2,080	2,080	27,350	13.15
Alzheimer's Coordinator	16	16	497	31.06
Marketing	1,574	1,714	35,214	20.54
TOTAL	7,441	7,706	186,551	

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue VandeRostyne	Administrator	0	$ 99,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 99,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 281,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 281,800

C. Professional Services

Vendor/Payee	Type	Amount
Mediacom	Computer Services	$ 1,598
Ability Network Services	Data Services	7,391
Livingston, Barger, Brandt	Legal Filing Fees-1/20/20	54
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 9,043

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,932
Unemployment Compensation Insurance	24,143
FICA Taxes	171,920
Employee Health Insurance	16,983
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,591
Home Office Allocation	12,732
Employee Retirement	1,407
Administrator Benefits	19,800
TOTAL (agree to Schedule V, line 22, col.8)	$ 281,508

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	251
Health Care Worker Background Check	
(Indicate # of checks performed 32)	
Patient Background Checks 44	1,310
Miscellaneous Licenses & Permits	717
Miscellaneous Dues & Subscriptions	330
Home Office Allocation	3,829
Less: Public Relations Expense	(330)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,107

G. Schedule of Travel and Seminar**

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

**See instructions.

Toulon Rehab Health Care Ctr
0052258
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)		9,043
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	433
Duane Morris	Legal	9,266
Lexis Nexis	Legal	12
Livingston, Barger, Brant, Schroeder	Legal	3,302
Miller, Hall, Triggs	Legal	75
Miscellaneous	Legal	28
SB2	Legal	223
SmithAmundsen LLC	Legal	1,382
Sorling Northrup	Legal	394
Mauer and Madoff	Legal	645
Illinois Secretary of State	Legal	195
Sedgwick Claims Management	Legal	10,748
Huntington Bank	Legal	300
CliftonLarsonAllen	Accounting	8,357
Ginoli & Co.	Accounting	8,168
Ability Network	Computer Services	4,410
Allscripts	Computer Services	696
AOD Matrix Care	Computer Services	7,744
AT&T	Computer Services	8
ATS	Computer Services	422
CCH	Computer Services	25
Charter Communications	Computer Services	39
Citrix Systems	Computer Services	132
Comcast	Computer Services	45
ITSavvy	Computer Services	204
Kemper Technology	Computer Services	1,006
Miscellaneous	Computer Services	195
Pearl Technology	Computer Services	182
Stratus Networks	Computer Services	800
TR Professional	Computer Services	17
David Budde	Other Prof Fees	18
DJ Howard and Associates	Other Prof Fees	34
Getzler Henrich & Associates	Other Prof Fees	136
LRI Consulting Services	Other Prof Fees	133
McQuellon Consulting	Other Prof Fees	84
Miscellaneous	Other Prof Fees	158
Optimizer	Other Prof Fees	72
Registered Agent Solutions	Other Prof Fees	40
RSM McGladrey	Other Prof Fees	437
SB2	Other Prof Fees	3,246
Sedgwick CMS	Other Prof Fees	4,579
Tarver Program Consultants	Other Prof Fees	104
Total (agree to Schedule V, line 19, column 8)		77,537

Toulon Rehab Health Care Ctr
0052258
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 21B

25. Administrative and Staff Transportation

Gas	$	6,374
Auto Repairs		2,831
Mileage-Travel		2,136
Home Office Allocation		5,359
		16,700

Facility Name & ID Number Toulon Rehab Health Care Ctr # 0052258 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. $ **34,890** 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. $ **205,989**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,560**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **3,168**
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.