

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0050625</u></p> <p>Facility Name: <u>Whispering Oaks</u></p> <p>Address: <u>201 Spring Street</u> <u>Rosiclare</u> <u>62982</u> <small>Number City Zip Code</small></p> <p>County: <u>Hardin</u></p> <p>Telephone Number: <u>(618)285-6974</u> Fax # <u>(618) 289-4860</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/28/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p align="center"> I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. </p> <p align="center"> Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. </p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="center"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Whispering Oaks

0050625 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	2,288			2,288	13
14	TOTALS	2,288			2,288	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.18%

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 NO

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

I. On what date did you start providing long term care at this location?
Date started 2/28/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/28/2006 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 Whispering Oaks # 0050625 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	3,419	1,015		4,434	4,434	609	5,043		1	
2	Food Purchase		13,910		13,910	13,910		13,910		2	
3	Housekeeping		4,800		4,800	4,800	12	4,812		3	
4	Laundry		2,389		2,389	2,389		2,389		4	
5	Heat and Other Utilities			15,112	15,112	15,112	(61)	15,051		5	
6	Maintenance		2,168	10,005	12,173	12,173	366	12,539		6	
7	Other (specify):*									7	
8	TOTAL General Services	3,419	24,282	25,117	52,818	52,818	926	53,744		8	
	B. Health Care and Programs										
9	Medical Director			3,600	3,600	3,600		3,600		9	
10	Nursing and Medical Records	173,090	8,510	5,745	187,345	187,345	1,088	188,433		10	
10a	Therapy									10a	
11	Activities	12,979	113		13,092	13,092		13,092		11	
12	Social Services									12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	186,069	8,623	9,345	204,037	204,037	1,088	205,125		16	
	C. General Administration										
17	Administrative	50,496		15,200	65,696	65,696	(11,812)	53,884		17	
18	Directors Fees									18	
19	Professional Services			621	621	621	2,274	2,895		19	
20	Dues, Fees, Subscriptions & Promotions			243	243	243	312	555		20	
21	Clerical & General Office Expenses		400	4,083	4,483	4,483	3,777	8,260		21	
22	Employee Benefits & Payroll Taxes			36,189	36,189	36,189	1,037	37,226		22	
23	Inservice Training & Education						6	6		23	
24	Travel and Seminar						2	2		24	
25	Other Admin. Staff Transportation			1,129	1,129	1,129	436	1,565		25	
26	Insurance-Prop.Liab.Malpractice			10,234	10,234	10,234	67	10,301		26	
27	Other (specify):*									27	
28	TOTAL General Administration	50,496	400	67,699	118,595	118,595	(3,901)	114,694		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	239,984	33,305	102,161	375,450	375,450	(1,887)	373,563		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.

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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			22,745	22,745		22,745	420	23,165		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							30	30		32
33	Real Estate Taxes			4,910	4,910		4,910	24	4,934		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			2,768	2,768		2,768	221	2,989		35
36	Other (specify):*										36
37	TOTAL Ownership			30,423	30,423		30,423	695	31,118		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			14,834	14,834		14,834		14,834		42
43	Other (specify):*		25	3,467	3,492		3,492	(3,492)			43
44	TOTAL Special Cost Centers		25	18,301	18,326		18,326	(3,492)	14,834		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	239,984	33,330	150,885	424,199		424,199	(4,684)	419,515		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,170)	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	(197)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,301)	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				24
25	Fund Raising, Advertising and Promotional	(25)	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	(99)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,792)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(892)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (892)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,684)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Whispering Oaks

ID# 0050625

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	4	43	1
2	Offset Refund on Co-Op Electricity	(103)	5	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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	(99)		49

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 609	\$	609	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%	12		12	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	42		42	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	366		366	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%	571		571	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	15,200	Petersen Health Care Management, Inc.	100.00%	3,388		(11,812)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	2,001		2,001	12
13	V								13
14	Total		\$ 15,200			\$ 6,989	\$ *	(8,211)	14

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

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. 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%	\$ 312	\$	312	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	3,777		3,777	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	1,037		1,037	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	6		6	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	2		2	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	436		436	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	67		67	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	617		617	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0		0	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	30		30	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	24		24	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	221		221	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		\$			\$ 6,529	\$ *	6,529	39

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

Facility Name & ID Number

Whispering Oaks

0050625

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. 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	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%			17
18	V	5 Utilities		Petersen Health Network, LLC	100.00%			18
19	V	6 Maintenance		Petersen Health Network, LLC	100.00%			19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			20
21	V	9 Medical Director		Petersen Health Network, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	517	517	22
23	V	10A Therapy		Petersen Health Network, LLC	100.00%			23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			24
25	V	17 Administrative		Petersen Health Network, LLC	100.00%			25
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	273	273	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%			27
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%			28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Network, LLC	100.00%			29
30	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%			30
31	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%			31
32	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%			32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%			33
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%			34
35	V	31 Amortization		Petersen Health Network, LLC	100.00%			35
36	V	32 Interest		Petersen Health Network, LLC	100.00%			36
37	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%			38
39	Total		\$			\$ 790	\$ * 790	39

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

Facility Name & ID Number

Whispering Oaks

0050625

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 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

Facility Name & ID Number

Whispering Oaks

0050625

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

Whispering Oaks

0050625

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

Whispering Oaks

0050625

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 Whispering Oaks # 0050625 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	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 Whispering Oaks

0050625

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	2,288	\$ 609	1
2	2	Food	Resident Days	1,282,791	75	0	0	2,288	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	2,288	12	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	2,288	42	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	2,288	366	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	2,288	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	2,288	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	2,288	571	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	2,288	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	2,288	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	2,288	3,388	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	2,288	2,001	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	2,288	312	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	2,288	3,777	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	2,288	1,037	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	2,288	6	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	2,288	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	2,288	436	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	2,288	67	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	2,288	617	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	2,288	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	2,288	30	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	2,288	24	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	2,288	221	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 13,518	25

Facility Name & ID Number Whispering Oaks

0050625

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 NO

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

Name of Related Organization Petersen Health Network, 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	71,843	7	\$	\$	2,288	\$	1
2	2	Food	Resident Days	71,843	7			2,288		2
3	3	Housekeeping	Resident Days	71,843	7			2,288		3
4	5	Utilities	Resident Days	71,843	7			2,288		4
5	6	Maintenance	Resident Days	71,843	7			2,288		5
6	7	Mgmt. Allocation of Benefits	Resident Days	71,843	7			2,288		6
7	9	Medical Director	Resident Days	71,843	7			2,288		7
8	10	Nursing and Medical Records	Resident Days	71,843	7	16,242		2,288	517	8
9	10A	Therapy	Resident Days	71,843	7			2,288		9
10	15	Mgmt. Allocation of Benefits	Resident Days	71,843	7			2,288		10
11	17	Administrative	Resident Days	71,843	7			2,288		11
12	19	Professional Services	Resident Days	71,843	7	8,567		2,288	273	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	71,843	7			2,288		13
14	21	Clerical and General Office	Resident Days	71,843	7			2,288		14
15	22	Employee Benefits and Payroll Ta	Resident Days	71,843	7			2,288		15
16	23	Inservice Training & Education	Resident Days	71,843	7			2,288		16
17	24	Travel and Seminar	Resident Days	71,843	7			2,288		17
18	25	Other Admin. Staff Transport.	Resident Days	71,843	7			2,288		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	71,843	7			2,288		19
20	30	Depreciation	Resident Days	71,843	7			2,288		20
21	31	Amortization	Resident Days	71,843	7			2,288		21
22	32	Interest	Resident Days	71,843	7			2,288		22
23	33	Real Estate Taxes	Resident Days	71,843	7			2,288		23
24	35	Rent-Equipment & Vehicles	Resident Days	71,843	7			2,288		24
25	TOTALS					\$ 24,809	\$		\$ 790	25

Facility Name & ID Number

Whispering Oaks

0050625

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			X				\$	\$				\$	1					
2													2					
3													3					
4													4					
5													5					
	Working Capital																	
6													6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$				\$	9					
	B. Non-Facility Related*																	
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	30					
15	TOTALS (line 9+line14)						\$	\$				\$	30					

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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.		\$	5,158	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.)		\$	4,992	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(166)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	5,076	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			24	
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.		\$	4,934	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	5,213	8
	2016	5,301	9
	2017	5,200	10
	2018	5,071	11
	2019	4,992	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Whispering Oaks COUNTY Hardin

FACILITY IDPH LICENSE NUMBER 0050625

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) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>06-82-057-08-000</u>	<u>Long-Term Care Facility</u>	\$ <u>4,991.80</u>	\$ <u>4,991.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>4,991.80</u></u>	\$ <u><u>4,991.80</u></u>

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 Whispering Oaks

0050625 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,320 B. General Construction Type: Exterior Vinyl Siding Frame Wood Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>10,000</u>	<u>2006</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	10,000		\$ 10,000	3

Facility Name & ID Number Whispering Oaks

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Report Period Beginning:

1/1/2020

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12/31/2020

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	2006	1994	\$ 530,000	\$	25	\$ 21,200	\$ 21,200	\$ 307,242
5									
6									
7									
8									
Improvement Type**									
9	A/C Unit		2009	2,985		5			2,985
10	A/C Unit		2010	3,860		15	258	258	2,709
11	Water Line Repair		2019	2,721		7	388	388	582
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	Building Booked				21,200			(21,200)	
32	Building Improvement Booked				622			(622)	
33									
34	2020-Home Office Allocation-Building Improvements			1,157			28	28	
35	2020-Home Office Allocation-Land Improvements			116			7	7	
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 Whispering Oaks

0050625

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								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								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 540,839	\$ 21,822		\$ 21,881	\$ 59	\$ 313,518	70

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

Facility Name & ID Number Whispering Oaks

0050625

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	\$ 3,584	\$ 290	\$ 317	\$ 27	5-10 yrs.	\$ 2,554	71
72	Current Year Purchases	4,428	633	385	(248)	7 yrs.	385	72
73	Fully Depreciated Assets	68,052					68,052	73
74	Home Office Allocation			582	582			74
75	TOTALS	\$ 76,064	\$ 923	\$ 1,284	\$ 361		\$ 70,991	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 626,903	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,165	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 420	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 384,509	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 Whispering Oaks

0050625

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 2,989 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.

Whispering Oaks

0050625

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	\$ -
Dishwasher	-
Copier	2,768
Home Office Allocation	221
	<u>2,989</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Whispering Oaks

0050625

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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 350	\$ 350	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 754)	37,710	37,710	3
4	Supply Inventory (priced at Cost)	1,616	1,616	4
5	Short-Term Investments			5
6	Prepaid Insurance	5,493	5,493	6
7	Other Prepaid Expenses	203	203	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 45,372	\$ 45,372	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	530,000	531,157	14
15	Leasehold Improvements, at Historical Cost	9,566	9,682	15
16	Equipment, at Historical Cost	76,064	76,064	16
17	Accumulated Depreciation (book methods)	(387,593)	(384,509)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,801	2,801	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 240,838	\$ 245,195	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 286,210	\$ 290,567	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 71,974	\$ 71,974	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,276	10,276	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,076	5,076	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	11,173	11,173	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 98,499	\$ 98,499	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 98,499	\$ 98,499	46
47	TOTAL EQUITY (page 18, line 24)	\$ 187,711	\$ 192,068	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 286,210	\$ 290,567	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 239,057	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(8,970)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 230,087	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(42,376)	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)	\$ (42,376)	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)	\$ 187,711	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Whispering Oaks

0050625

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 355,316	1
2	Discounts and Allowances for all Levels	(49,377)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 305,939	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous and COVID Stimulus Revenue	75,884	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 75,884	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 381,823	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	52,818	31
32	Health Care	204,037	32
33	General Administration	118,595	33
B. Capital Expense			
34	Ownership	30,423	34
C. Ancillary Expense			
35	Special Cost Centers	3,492	35
36	Provider Participation Fee	14,834	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 424,199	40
41	Income before Income Taxes (line 30 minus line 40)**	(42,376)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (42,376)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 305,939	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 305,939	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 Whispering Oaks

0050625

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
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	16,790	17,241	172,346	10.00
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	865	905	12,979	14.34
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	340	340	3,419	10.06
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	1,969	2,085	50,496	24.22
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>Daily Living Aide</u>	46	46	744	16.17
34	TOTAL (lines 1 - 33)	20,010	20,617	\$ 239,984 *	\$ 11.64

* 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			35
36	Medical Director	Monthly 3,600	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly 6,000	L10, C3	38
39	Pharmacist Consultant	Monthly (255)	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 9,345		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Whispering Oaks

0050625

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	1	42,455	#####
Transportation			18,096	#DIV/0!
Marketing			33,727	#DIV/0!
TOTAL	1	1	94,278	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount			
Jessica Hershey	Administrator	0	\$ 25,366	Workers' Compensation Insurance		\$ 3,874		IDPH License Fee		\$			
Kellie Stanford	Administrator	0	25,130	Unemployment Compensation Insurance		2,881		Advertising: Employee Recruitment					
				FICA Taxes		14,098		Health Care Worker Background Check					
				Employee Health Insurance		4,502		(Indicate # of checks performed <u>2</u>)		(60)			
				Employee Meals				Patient Background Checks	<u>1</u>	30			
				Illinois Municipal Retirement Fund (IMRF)*				Miscellaneous Licenses & Permits		273			
				Home Office Allocation		1,037		Home Office Allocation		312			
				Employee Retirement		130							
				Administrator Benefits		10,704							
TOTAL (agree to Schedule V, line 17, col. 1)													
(List each licensed administrator separately.)			\$ 50,496										
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				Less: Public Relations Expense ()					
Description			Amount	Description			Amount	Non-allowable advertising ()					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 15,200	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 555	Yellow page advertising ()					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 15,200	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**						
(Attach a copy of any management service agreement)				Description			Line #	Amount	Description			Amount	
C. Professional Services				Description				Line #	Amount	Out-of-State Travel			Amount
Vendor/Payee	Type		Amount	Description			Line #	Amount	In-State Travel				
Shawnee Communications	Computer Services		\$ 621	N/A					Seminar Expense				
Healthcare and Family Services	Legal Fees-12/20/19			TOTAL					Home Office Allocation			2	
									Entertainment Expense ()				
									TOTAL (agree to Sch. V, line 24, col. 8)			\$ 2	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 621										
(For legal fee disclosure, see page 39 of instructions)													

* Attach copy of IMRF notifications

**See instructions.

Whispering Oaks

0050625

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)		621
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	35
Duane Morris	Legal	101
Lexis Nexis	Legal	1
Livingston, Barger, Brant, Schroeder	Legal	2
Miller, Hall, Triggs	Legal	6
Miscellaneous	Legal	2
SB2	Legal	18
SmithAmundsen LLC	Legal	113
Sorling Northrup	Legal	32
Illinois Secretary of State	Legal	63
CliftonLarsonAllen	Accounting	140
Ginoli & Co.	Accounting	258
Ability Network	Computer Services	359
Allscripts	Computer Services	57
AOD Matrix Care	Computer Services	631
AT&T	Computer Services	1
ATS	Computer Services	34
CCH	Computer Services	2
Charter Communications	Computer Services	3
Citrix Systems	Computer Services	11
Comcast	Computer Services	4
ITSavvy	Computer Services	17
Kemper Technology	Computer Services	82
Miscellaneous	Computer Services	16
Pearl Technology	Computer Services	15
Stratus Networks	Computer Services	65
TR Professional	Computer Services	1
David Budde	Other Prof Fees	1
DJ Howard and Associates	Other Prof Fees	3
Getzler Henrich & Associates	Other Prof Fees	11
LRI Consulting Services	Other Prof Fees	11
McQuellon Consulting	Other Prof Fees	7
Miscellaneous	Other Prof Fees	12
Optimizer	Other Prof Fees	6
Registered Agent Solutions	Other Prof Fees	3
RSM McGladrey	Other Prof Fees	36
SB2	Other Prof Fees	46
Sedgwick CMS	Other Prof Fees	61
Tarver Program Consultants	Other Prof Fees	8
Total (agree to Schedule V, line 19, column 8)		<u>2,895</u>

Whispering Oaks

0050625

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	30
Auto Repairs		797
Mileage-Travel		302
Home Office Allocation		436
		<u>1,565</u>

Facility Name & ID Number Whispering Oaks# 0050625Report Period Beginning: 1/1/2020Ending: 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. \$ 841 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. \$ 14,834
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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? 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 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.