

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0047076</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																							
Facility Name: <u>Auburn Rehab HCC</u>		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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																																																							
Address: <u>304 Maple Avenue</u> <u>Auburn</u> <u>62615</u>																																																																																									
Number City Zip Code																																																																																									
County: <u>Sangamon</u>																																																																																									
Telephone Number: <u>(217) 438-6125</u> Fax # <u>(217) 438-6316</u>																																																																																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Ste. 1800, St. Louis, MO 63101</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>10/15/2005</u></td><td colspan="2">(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table></td><td colspan="2">ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2">201 S. Grand Avenue East</td></tr><tr><td colspan="2">Name: <u>Kevin Wellen, CPA</u></td><td colspan="2">Springfield, IL 62763-0001</td></tr><tr><td colspan="2">Telephone Number: <u>(314) 925-4300</u></td><td colspan="2">Phone # (217) 782-1630</td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u>	(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Ste. 1800, St. Louis, MO 63101</u>	Date of Initial License for Current Owners: <u>10/15/2005</u>		(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES		In the event there are further questions about this report, please contact:		201 S. Grand Avenue East		Name: <u>Kevin Wellen, CPA</u>		Springfield, IL 62763-0001		Telephone Number: <u>(314) 925-4300</u>		Phone # (217) 782-1630		Email Address: _____			
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#	0047076	Report Period Beginning:	1/1/2020	Ending:	12/31/2020
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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 **5/16/2005**

J. Was the facility purchased or leased after January 1, 1978?
 YES ☒ X Date 5/16/2005 NO

K. Was the facility certified for Medicare during the reporting year?
 YES ☒ NO ☐ If YES, enter number
 of beds certified 70 and days of care provided

Medicare Intermediary Wisonsin Physician Services

MODIFIED

ACCRUAL	X	CASH*		CASH*	
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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.**

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	73.36%
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Facility Name & ID Number Auburn Rehab HCC # 0047076 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		5,669	300,713	306,382		306,382		306,382			1
2	Food Purchase		12,412		12,412		12,412		12,412			2
3	Housekeeping		17,178	105,086	122,264		122,264		122,264			3
4	Laundry		8,120	68,374	76,494		76,494		76,494			4
5	Heat and Other Utilities			92,712	92,712		92,712		92,712			5
6	Maintenance	57,221	9,533	66,239	132,993		132,993		132,993			6
7	Other (specify):*											7
8	TOTAL General Services	57,221	52,912	633,124	743,257		743,257		743,257			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,480,097	99,431	254,006	1,833,534		1,833,534	(15,000)	1,818,534			10
10a	Therapy											10a
11	Activities	72,720	8,771	3,483	84,974		84,974		84,974			11
12	Social Services	44,036		7,977	52,013		52,013		52,013			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,596,853	108,202	283,466	1,988,521		1,988,521	(15,000)	1,973,521			16
	C. General Administration											
17	Administrative	101,009		206,772	307,781		307,781	28,367	336,148			17
18	Directors Fees											18
19	Professional Services			79,035	79,035		79,035	(27,180)	51,855			19
20	Dues, Fees, Subscriptions & Promotions			19,406	19,406		19,406	(1,624)	17,782			20
21	Clerical & General Office Expenses	105,578	33,290	156,829	295,697		295,697	(104,380)	191,317			21
22	Employee Benefits & Payroll Taxes			258,926	258,926		258,926		258,926			22
23	Inservice Training & Education			211	211		211		211			23
24	Travel and Seminar			3,602	3,602		3,602		3,602			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,591	71,591		71,591		71,591			26
27	Other (specify):*											27
28	TOTAL General Administration	206,587	33,290	796,372	1,036,249		1,036,249	(104,817)	931,432			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,860,661	194,404	1,712,962	3,768,027		3,768,027	(119,817)	3,648,210			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			28,373	28,373		28,373	57,808	86,181			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,239	9,239		9,239	(9,239)				32
33	Real Estate Taxes			24,303	24,303		24,303		24,303			33
34	Rent-Facility & Grounds			96,000	96,000		96,000	(96,000)				34
35	Rent-Equipment & Vehicles			4,143	4,143		4,143		4,143			35
36	Other (specify):*											36
37	TOTAL Ownership			162,058	162,058		162,058	(47,431)	114,627			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,548	370,729	505,277		505,277		505,277			39
40	Barber and Beauty Shops		160		160		160		160			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,658	138,658		138,658		138,658			42
43	Other (specify):* Marketing	36,461		29,100	65,561		65,561	(65,561)				43
44	TOTAL Special Cost Centers	36,461	134,708	538,487	709,656		709,656	(65,561)	644,095			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,897,122	329,112	2,413,507	4,639,741		4,639,741	(232,809)	4,406,932			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(872)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(11,580)	21		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	(73,618)	21		24
25	Fund Raising, Advertising and Promotional	(21,277)	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	(46,367)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,714)		\$	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)	(79,095)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (79,095)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (232,809)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Portion of Dues	\$ (1,316)	20	1
2	PAC Dues	(308)	20	2
3	Marketing Salaries	(36,461)	43	3
4	Marketing Benefits	(7,823)	43	4
5	Miscellaneous Income	(459)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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	(46,367)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Auburn Rehab HCC# 0047076

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	16
	C. General Administration													
17	Administrative	0	0	28,367	0	0	0	0	0	0	0	0	28,367	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(27,180)	0	0	0	0	0	0	0	0	(27,180)	19
20	Fees, Subscriptions & Promotions	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	20
21	Clerical & General Office Expenses	(85,657)	277	(19,000)	0	0	0	0	0	0	0	0	(104,380)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(87,281)	277	(17,813)	0	0	0	0	0	0	0	0	(104,817)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,281)	277	(32,813)	0	0	0	0	0	0	0	0	(119,817)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	55,559	2,249	0	0	0	0	0	0	0	0	57,808	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(872)	872	(9,239)	0	0	0	0	0	0	0	0	(9,239)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(96,000)	0	0	0	0	0	0	0	0	0	(96,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(872)	(39,569)	(6,990)	0	0	0	0	0	0	0	0	(47,431)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(65,561)	0	0	0	0	0	0	0	0	0	0	(65,561)	43
44	TOTAL Special Cost Centers	(65,561)	0	0	0	0	0	0	0	0	0	0	(65,561)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(153,714)	(39,292)	(39,803)	0	0	0	0	0	0	0	0	(232,809)	45

VII. RELATED PARTIES

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

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

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Administrative	\$	JCT FLP Auburn LLC		\$ 277	\$ 277	1
2	V	34	Rent	96,000	JCT FLP Auburn LLC			(96,000)	2
3	V	32	Interest		JCT FLP Auburn LLC		872	872	3
4	V	30	Depreciation		JCT FLP Auburn LLC		55,559	55,559	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 96,000			\$ 56,708	\$ * (39,292)	14

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

Facility Name & ID Number Auburn Rehab HCC# 0047076Report Period Beginning: 1/1/2020Ending: 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 Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Insurance	\$ 2,629	CarePlus Health Plus		\$ 2,629	\$ 15
16	V	26 Insurance	40,271	Cost Plus Insurance		40,271	16
17	V	26 Insurance	64,527	LTC Plus Insurance, Inc.		64,527	17
18	V	17 Management-Operating	206,772	Tutera Health Care Service		235,139	28,367 18
19	V	19 Management-Data Processing	27,180	Tutera Health Care Service			(27,180) 19
20	V	30 Management-Depreciation		Tutera Health Care Service		2,249	2,249 20
21	V	10 Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000) 21
22	V	21 Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000) 22
23	V	32 Interest	9,239	Tutera Investments			(9,239) 23
24	V	11 Activities - Supplies	18	Walnut Creek Management Company, LLC		18	
25	V	10 Nursing Admin - purchased svcs	2,655	Walnut Creek Management Company, LLC		2,655	
26	V	24 Travel & Seminar	208	Walnut Creek Management Company, LLC		208	
27	V	6 Maintenance & Repairs	9,203	Walnut Creek Management Company, LLC		9,203	
28	V	43 Marketing	285	Walnut Creek Management Company, LLC		285	
29	V	23 Inservice Training	211	Walnut Creek Management Company, LLC		211	
30	V	19 Purchased Svcs/Data Processing	7,692	Walnut Creek Management Company, LLC		7,692	
31	V	20 Help Wanted Ads & Licenses	5,181	Walnut Creek Management Company, LLC		5,181	
32	V	21 Supplies, Sm Equip, Postage	13,087	Walnut Creek Management Company, LLC		13,087	
33	V	21 Employment Expense	9,620	Critical Care Rx, LLC		9,620	
34	V	10 Pharmacy Consultant	5,385	Critical Care Rx, LLC		5,385	
35	V	39 Drugs	82,032	Critical Care Rx, LLC		82,032	
36	V	39 IV Therapy & Supplies	22,799	Critical Care Rx, LLC		22,799	
37	V						
38	V						
39	Total		\$ 542,994			\$ 503,191	\$ * (39,803) 39

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

Facility Name & ID Number

Auburn Rehab HCC

0047076

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	Tutera Investments, Inc	99%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT FLP, LLC	1%	Bethany Rehab & Health Care Center	DeKlb, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3			Carlinsville Rehab & Health Care Center	Carlinsville, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Dixon, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Seni	Prairie Village, KS	AL/IL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Kansas City, MO	AL/IL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL	JCT FLP Auburn LLC	Aurora, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New Eng	Kansas City, MO	Mgmt Company	19
20			St. Paul's Senior Community	Belleville, IL	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Tutera Investments, LI	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Overland Park, KS	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Belton, MO	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Kansas City, MO	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Kansas City, MO				25
26								26
27								27
28								28
29								29
30								30

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Auburn Rehab HCC# 0047076

Report Period Beginning:

1/1/2020Ending: 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

Tutera Health Care Services

Street Address

7611 State Line Road

City / State / Zip Code

Kansas City, Missouri 64114

Phone Number

(816) 444-0900

Fax Number

(816) 822-0081

	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	17	Management Fee- Operating	Direct Costs	287,210,821	71	\$ 15,078,459	\$ 10,830,799	4,478,940	\$ 235,143	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		4,478,940	2,249	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 15,222,689	\$ 10,830,799		\$ 237,392	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Tutera Investments, LLC	x		Note Payable			\$ 422,000	\$ 780,013			\$ 9,239	1
2	Tutera Group, Inc	x		Note Payable			139,475	100,347			872	2
3	Related Party Interest Offset - Tutera Investments										(9,239)	3
4	Interest Income Offset (to the extent of expense)										(872)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 561,475	\$ 880,360			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 561,475	\$ 880,360			\$	15

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

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

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

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.			\$	24,303	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.)			\$	24,249	2																																			
3. Under or (over) accrual (line 2 minus line 1).			\$	(54)	3																																			
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	24,357	4																																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	24,303	7																																			
Real Estate Tax History:																																								
Real Estate Tax Bill for Calendar Year:		<table><tr><td>2015</td><td>20,862</td><td>8</td></tr><tr><td>2016</td><td>19,071</td><td>9</td></tr><tr><td>2017</td><td>23,896</td><td>10</td></tr><tr><td>2018</td><td>23,232</td><td>11</td></tr><tr><td>2019</td><td>24,249</td><td>12</td></tr></table>	2015	20,862	8	2016	19,071	9	2017	23,896	10	2018	23,232	11	2019	24,249	12	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2019</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>				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
2015	20,862	8																																						
2016	19,071	9																																						
2017	23,896	10																																						
2018	23,232	11																																						
2019	24,249	12																																						
	FOR BHF USE ONLY																																							
13	FROM R. E. TAX STATEMENT FOR 2019	\$	13																																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																																					
15	LESS REFUND FROM LINE 6	\$	15																																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																					

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Auburn Rehab HCC COUNTY Sangamon
FACILITY IDPH LICENSE NUMBER 0047076
CONTACT PERSON REGARDING THIS REPORT Kiley Brooks
TELEPHONE (816) 444-0900 FAX #: ()

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.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,405

B. General Construction Type: Exterior Brick Frame Brick 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).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long-Term Care		2017	\$ 126,513	1
2					2
3	TOTALS			\$ 126,513	3

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	70		2017		\$ 1,012,103	\$ 37,485	27	\$ 37,485	\$	\$ 146,817
5										
6										
7										
8										
	Improvement Type**									
9	2006 Improvements		2006		13,129	180	Various	180		12,711
10	2009 Improvements		2009		13,601	364	Various	364		10,475
11	2010 Improvements		2010		60,032	1,740	Various	1,740		51,374
12	2011 Improvements		2011		41,919	3,837	Various	3,837		37,634
13	HVAC Replacement		2014		19,728	1,973	10	1,973		12,659
14	South Hall Shower Renovations - enlarged w/ new materials, plumbing, drywall, paint and tile		2016		30,282	2,019	15	2,019		9,758
15										
16	South Hall Shower Renovations - plumbing, drywal, tile and paint		2017		22,795	3,256	7	3,256		11,126
17	Circuit Panel		2017		13,940	507	27	507		1,774
18	New Boiler		2018		13,577	905	15	905		2,338
19	Trance Condensing Unit		2019		9,525	635	15	635		741
20	Home Office Depreciation					2,249		2,249		
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

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	N/A		\$	\$		\$	\$	\$	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)		\$ 1,250,631	\$ 55,150		\$ 55,150	\$	\$ 297,407	70

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

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	\$ 151,568	\$ 21,114	\$ 21,114	\$	Various	\$ 80,049	71
72	Current Year Purchases	5,960	780	780		7	780	72
73	Fully Depreciated Assets	185,375	718	718		Various	185,375	73
74								74
75	TOTALS	\$ 342,903	\$ 22,612	\$ 22,612	\$		\$ 266,204	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	Patient Transportation	Ford Transit Bus 2019	2019	\$ 42,093	\$ 8,419	\$ 8,419	\$	5	\$ 9,822
77									77
78									78
79									79
80	TOTALS			\$ 42,093	\$ 8,419	\$ 8,419	\$		\$ 9,822

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 1,762,140
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 86,181
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 86,181
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 573,433

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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?
16. Rental Amount for movable equipment: \$ 4,143 Description: Nrsrg Equip, Dishwasher, Copier (See WTB)
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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.

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	\$

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
☒ 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)	\$			

(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.

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	

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	V39-03	hrs	\$	2,500	\$ 155,809	\$	2,500	\$ 155,809	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		617	42,791	47	617	42,838	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		2,543	151,398	285	2,543	151,683	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescripts				85,217		85,217	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB	V39-02,03				20,731	48,999		69,730	13
14	TOTAL			\$	5,660	\$ 370,729	\$ 134,548	5,660	\$ 505,277	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.

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	\$ 107,511	\$ 163,243	1
2	Cash-Patient Deposits	38,263	38,263	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	228,945	228,945	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,236	78,236	6
7	Other Prepaid Expenses	237,142	237,142	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	172,988	172,988	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 863,085	\$ 918,817	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		126,513	13
14	Buildings, at Historical Cost		1,012,103	14
15	Leasehold Improvements, at Historical Cost	238,529	238,529	15
16	Equipment, at Historical Cost	258,481	384,995	16
17	Accumulated Depreciation (book methods)	(355,829)	(573,433)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe FA ADJ & Accum De	(123,637)	(1,035,612)	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,544	\$ 153,095	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 880,629	\$ 1,071,912	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 341,220	\$ 341,220	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,263	38,263	28
29	Short-Term Notes Payable	780,013	880,360	29
30	Accrued Salaries Payable	71,907	71,907	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,690	22,690	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,357	24,357	32
33	Accrued Interest Payable			33
34	Deferred Compensation	552,212	552,212	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident and Employee Donations	12,082	12,082	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,842,744	\$ 1,943,091	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)	\$ 1,842,744	\$ 1,943,091	46
47	TOTAL EQUITY (page 18, line 24)	\$ (962,115)	\$ (871,179)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 880,629	\$ 1,071,912	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (606,913)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (606,913)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(355,202)	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)	\$ (355,202)	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)	\$ (962,115)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Auburn Rehab HCC

0047076

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	\$ 3,317,713	1
2	Discounts and Allowances for all Levels	(1,698,144)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,619,569	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,277,359	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,277,359	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	(4,269)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	164,633	17
18	Sale of Supplies to Non-Patients	5,710	18
19	Laboratory		19
20	Radiology and X-Ray	2,016	20
21	Other Medical Services	45,710	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	364	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 364	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	459	28
28a	COVID-19 PHE Funding	172,988	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 173,447	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,284,539	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	743,257	31
32	Health Care	1,986,691	32
33	General Administration	1,038,079	33
	B. Capital Expense		
34	Ownership	162,058	34
	C. Ancillary Expense		
35	Special Cost Centers	570,998	35
36	Provider Participation Fee	138,658	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,639,741	40
41	Income before Income Taxes (line 30 minus line 40)**	(355,202)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (355,202)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,061,289	44
45	Private Pay - Net Inpatient Revenue	406,499	45
46	Medicare - Net Inpatient Revenue	(466,131)	46
47	Other-(specify) <u>Managed Care</u>	(400,079)	47
48	Other-(specify) <u>Hospice</u>	17,991	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,619,569	49

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

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

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

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

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	3,097	3,434	\$ 107,615	\$ 31.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,972	10,473	342,141	32.67	3
4	Licensed Practical Nurses	9,552	10,102	300,686	29.76	4
5	CNAs & Orderlies	37,917	39,428	702,051	17.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,881	2,181	34,648	15.89	9
10	Activity Assistants	2,776	2,925	38,072	13.02	10
11	Social Service Workers	2,183	2,322	44,036	18.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,321	2,542	57,221	22.51	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,840	1,920	101,009	52.61	20
21	Assistant Administrator					21
22	Other Administrative	380	380	6,263	16.48	22
23	Office Manager					23
24	Clerical	5,388	5,516	105,578	19.14	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	1,407	1,719	21,341	12.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,874	2,087	36,461	17.47	33
34	TOTAL (lines 1 - 33)	80,588	85,029	\$ 1,897,122 *	\$ 22.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	111	\$ 6,052	V01-3	35
36	Medical Director	160	18,000	V09-5	36
37	Medical Records Consultant	4	330	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,385	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,676	V113	44
45	Social Service Consultant	Monthly	2,676	V123	45
46	Other(specify) <u>Psych Consultant</u>	Monthly	5,500	V123	46
47					47
48					48
49	TOTAL (lines 35 - 48)	275	\$ 40,619		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,135	\$ 65,593	V10-3	50
51	Licensed Practical Nurses	794	58,077	V10-3	51
52	Certified Nurse Assistants/Aides	2,762	94,724	V10-3	52
53	TOTAL (lines 50 - 52)	4,690	\$ 218,394		53

STATE OF ILLINOIS

0047076

Report Period Beginning:

1/1/2020

Page 21

Ending: 12/31/2020

Facility Name & ID Number

Auburn Rehab HCC

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dan Krug	Administrator	0	\$ 101,009
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,009

B. Administrative - Other

Description	Amount
Tutera Health Care Services - Management Fees	\$ 206,772
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 206,772

C. Professional Services

Vendor/Payee	Type	Amount
Heyl Royster Voelker & Allen	Legal Services	\$ 175
Daniel Maher Law Offices	Legal Services	1,300
CliftonLarsonAllen LLP	Taxes/Cost Reports	6,705
Walnut Creek Mgmt Co LLC	Data Processing	33,824
PointClickCare Technologies LLC	Data Processing	16,483
Ability Netowrk Inc	Data Processing	5,075
Providigm LLC	Data Processing	2,520
Property Valuation Services	Valuation	100
Allscripts Healthcare LLC	Data Processing	4,916
Curaspan Health Group Inc	Professional Services	246
Pinnacle Quailty Insight	Quality Consultant	7,691
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 79,035

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 64,766
Unemployment Compensation Insurance	
FICA Taxes	149,932
Employee Health Insurance	44,228
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 258,926

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

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	9,430
Health Care Worker Background Check (Indicate # of checks performed)	464
Patient Background Checks	
IHCA PAC	308
IL Health Care Association	4,788
Sangamon County DPH License	944
Other Dues & Subscriptions	825
Other Licenses	657
Less: Public Relations Expense	(1,624)
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,782

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	3,602
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,602

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Health Care Association \$4,788

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,415 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 138,658
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ 0

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

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.