

		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>0049221</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Hillsboro 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>1300 East Tremont St</u> <u>Hillsboro</u> <u>62049</u>																																																	
Number City Zip Code																																																	
County: <u>Montgomery</u>																																																	
Telephone Number: <u>(217) 532-6191</u> Fax # <u>(217) 532-6194</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) _____</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u></td><td></td></tr><tr><td></td><td>(Telephone) <u>(314) 925-4300</u></td><td>Fax # <u>(314) 925-4350</u></td></tr></table> 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		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(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, Suite 1800, St. Louis, MO 63101</u>			(Telephone) <u>(314) 925-4300</u>	Fax # <u>(314) 925-4350</u>																													
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	(Telephone) <u>(314) 925-4300</u>	Fax # <u>(314) 925-4350</u>																																															
Date of Initial License for Current Owners: <u>2/1/2008</u>																																																	
Type of Ownership:																																																	
<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></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></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 _____		
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		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:																																																	
Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Hillsboro Rehab HCC

0049221 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 _____					
	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	121	Skilled (SNF)	121	44,286	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,286	7

B. Census-For the entire report period.						
	1 Level of Care	2				

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.26%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 2/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/1/2008 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 121 and days of care provided 3,674

Medicare Intermediary Wisconsin Physican Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ 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 Hillsboro Rehab HCC # 0049221 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		22,655	560,057	582,712		582,712		582,712			1
2	Food Purchase		1,378		1,378		1,378		1,378			2
3	Housekeeping		11,199	112,635	123,834		123,834		123,834			3
4	Laundry		11,340	74,572	85,912		85,912		85,912			4
5	Heat and Other Utilities			117,186	117,186		117,186		117,186			5
6	Maintenance	44,304	14,500	56,904	115,708		115,708		115,708			6
7	Other (specify):*											7
8	TOTAL General Services	44,304	61,072	921,354	1,026,730		1,026,730		1,026,730			8
	B. Health Care and Programs											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	1,924,369	101,863	555,687	2,581,919		2,581,919	(15,000)	2,566,919			10
10a	Therapy											10a
11	Activities	111,150	9,817	3,732	124,699		124,699		124,699			11
12	Social Services	36,034	216	2,458	38,708		38,708		38,708			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,071,553	111,896	580,377	2,763,826		2,763,826	(15,000)	2,748,826			16
	C. General Administration											
17	Administrative	53,597		341,219	394,816		394,816	(55)	394,761			17
18	Directors Fees											18
19	Professional Services			129,682	129,682		129,682	(35,261)	94,421			19
20	Dues, Fees, Subscriptions & Promotions			22,891	22,891		22,891	(2,554)	20,337			20
21	Clerical & General Office Expenses	124,484	33,828	293,769	452,081		452,081	(159,023)	293,058			21
22	Employee Benefits & Payroll Taxes			268,217	268,217		268,217		268,217			22
23	Inservice Training & Education			83	83		83		83			23
24	Travel and Seminar			2,616	2,616		2,616		2,616			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			155,283	155,283		155,283		155,283			26
27	Other (specify):*											27
28	TOTAL General Administration	178,081	33,828	1,213,760	1,425,669		1,425,669	(196,893)	1,228,776			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,293,938	206,796	2,715,491	5,216,225		5,216,225	(211,893)	5,004,332			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			18,580	18,580		18,580	100,581	119,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,458	5,458		5,458	43,555	49,013			32
33	Real Estate Taxes			45,304	45,304		45,304	(1,701)	43,603			33
34	Rent-Facility & Grounds			701,224	701,224		701,224	(701,224)				34
35	Rent-Equipment & Vehicles			3,415	3,415		3,415		3,415			35
36	Other (specify):* Mortgage Insurance Premium							8,012	8,012			36
37	TOTAL Ownership			773,981	773,981		773,981	(550,777)	223,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		294,517	619,045	913,562		913,562		913,562			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			241,045	241,045		241,045		241,045			42
43	Other (specify):* Marketing	44,218		26,220	70,438		70,438	(70,438)				43
44	TOTAL Special Cost Centers	44,218	294,517	886,310	1,225,045		1,225,045	(70,438)	1,154,607			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,338,156	501,313	4,375,782	7,215,251		7,215,251	(833,108)	6,382,143			45

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

	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	(3,926)	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	(15,043)	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	(124,707)	21		24
25	Fund Raising, Advertising and Promotional	(15,990)	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	(57,275)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (216,941)		\$	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)	(616,167)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (616,167)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (833,108)		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	Chamber of Commerce Dues	\$ (280)	20	1
2	Marketing Salaries	(44,218)	43	2
3	Marketing Benefits	(10,230)	43	3
4	Miscellaneous Income	(273)	21	4
5	Lobbying Portion of Dues	(2,274)	20	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
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21				21
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24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(57,275)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillsboro Rehab HCC# 0049221

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	(55)	0	0	0	0	0	0	0	0	(55)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,155	(46,416)	0	0	0	0	0	0	0	0	(35,261)	19
20	Fees, Subscriptions & Promotions	(2,554)	0	0	0	0	0	0	0	0	0	0	(2,554)	20
21	Clerical & General Office Expenses	(140,023)	0	(19,000)	0	0	0	0	0	0	0	0	(159,023)	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	(142,577)	11,155	(65,471)	0	0	0	0	0	0	0	0	(196,893)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(142,577)	11,155	(80,471)	0	0	0	0	0	0	0	0	(211,893)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	97,317	3,264	0	0	0	0	0	0	0	0	100,581	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,926)	52,939	(5,458)	0	0	0	0	0	0	0	0	43,555	32
33	Real Estate Taxes	0	(1,701)	0	0	0	0	0	0	0	0	0	(1,701)	33
34	Rent-Facility & Grounds	0	(701,224)	0	0	0	0	0	0	0	0	0	(701,224)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	8,012	0	0	0	0	0	0	0	0	0	8,012	36
37	TOTAL Ownership	(3,926)	(544,657)	(2,194)	0	0	0	0	0	0	0	0	(550,777)	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):*	(70,438)	0	0	0	0	0	0	0	0	0	0	(70,438)	43
44	TOTAL Special Cost Centers	(70,438)	0	0	0	0	0	0	0	0	0	0	(70,438)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(216,941)	(533,502)	(82,665)	0	0	0	0	0	0	0	0	(833,108)	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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER 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.

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)	
1	V	34	Rent	\$ 701,224	TI-Hillsboro, LLC	100.00%	\$	(701,224)	1
2	V	32	Interest		TI-Hillsboro, LLC	100.00%	46,344	46,344	2
3	V	19	Accounting & Legal		TI-Hillsboro, LLC	100.00%	11,155	11,155	3
4	V	36	Mortgage Insurance		TI-Hillsboro, LLC	100.00%	8,012	8,012	4
5	V	30	Depreciation		TI-Hillsboro, LLC	100.00%	97,317	97,317	5
6	V	32	Amortization of Fiancing Costs		TI-Hillsboro, LLC	100.00%	6,595	6,595	6
7	V	33	Real Estate Taxes	45,304	TI-Hillsboro, LLC	100.00%	43,603	(1,701)	7
8	V	26	Insurance	7,268	TI-Hillsboro, LLC	100.00%	7,268		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 753,796			\$ 220,294	\$ * (533,502)	14

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

Facility Name & ID Number Hillsboro Rehab HCC # 0049221 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 Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Insurance	\$ 3,003	CarePlus Health Plus		\$ 3,003	\$	15
16	V	22 Insurance	55,457	Cost Plus Insurance		55,457		16
17	V	26 Insurance	140,371	LTC Plus Insurance, Inc.		140,371		17
18	V	17 Management-Operating	341,219	Tutera Health Care Service		341,164	(55)	18
19	V	19 Management-Data Processing	46,416	Tutera Health Care Service			(46,416)	19
20	V	30 Management-Depreciation		Tutera Health Care Service		3,264	3,264	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	5,458	JCT Capital/Tutera Investments			(5,458)	23
24	V	11 Activities - Purchased Svcs	133	Carlinville Rehab and Healthcare		133		24
25	V	10 Nursing Staff	151	Carlinville Rehab and Healthcare		151		25
26	V	21 Employment Expense	698	Critical Care RX LLC		698		26
27	V	01 Dietary - Sm Equip	340	Critical Care RX LLC		340		27
28	V	39 IV Therapy & Supplies	11,112	Critical Care RX LLC		11,112		28
29	V	10 Pharmacy Consultant	8,895	Critical Care RX LLC		8,895		29
30	V	39 Drugs	102,865	Critical Care RX LLC		102,865		30
31	V	21 Purchased Svcs	2,783	Walnut Creek Management Company, LLC		2,783		31
32	V	06 Plant/Maintenance	1,794	Walnut Creek Management Company, LLC		1,794		32
33	V	24 Travel & Seminar	749	Walnut Creek Management Company, LLC		749		33
34	V	19 Purchased Svcs/Data Processing	8,198	Walnut Creek Management Company, LLC		8,198		34
35	V	20 Help Wanted Ads & Licenses	4,979	Walnut Creek Management Company, LLC		4,979		35
36	V	21 Supplies, Sm Equip, Postage	14,289	Walnut Creek Management Company, LLC		14,289		36
37	V							37
38	V							38
39	Total		\$ 782,910			\$ 700,245	\$ * (82,665)	39

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

Facility Name & ID Number

Hillsboro Rehab HCC

0049221

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			Carlville Rehab & Health Care Center	Carlville, 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			Auburn Rehab & Health Care Center	Auburn, 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				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 Hillsboro Rehab HCC# 0049221 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

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	6,498,470	\$ 341,167	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		6,498,470	3,263	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		\$ 344,430	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	HUD		X	Mortgage			\$	1,568,604			\$ 46,344	1
2	Amortize HUD Financing Costs		X								6,595	2
3	Interest Income Offset										(3,926)	3
4												4
5												5
	Working Capital											
6	Tutera Investments	X					692,239	499,788		0.0100	5,458	6
7	Related Party Offset										(5,458)	7
8												8
9	TOTAL Facility Related						\$ 692,239	\$ 2,068,392			\$ 49,013	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 692,239	\$ 2,068,392			\$ 49,013	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,012 Line # 36

* 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.		\$	43,603	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.)		\$	45,304	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,701	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	41,902	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.		\$	43,603	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	57,194	8	
		2016	55,902	9	
		2017	55,302	10	
		2018	42,748	11	
		2019	45,304	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillsboro Rehab HCC COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0049221

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

TELEPHONE (816) 444-0900 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-12-256-022	Long-term Care	\$ 45,304.42	\$ 45,304.42
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 45,304.42	\$ 45,304.42

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,819

B. General Construction Type: Exterior Brick Frame Block 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	16,819	2008	\$ 240,000	1
2					2
3	TOTALS	16,819		\$ 240,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121		2008	1975	\$ 2,460,000	\$ 63,077	39	\$ 63,077	\$	\$ 814,743	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2008 IMPROVEMENTS			2008	12,130		10			12,130	9
10	2009 IMPROVEMENTS			2009	1,309	87	15	87		1,011	10
11	2010 IMPROVEMENTS			2010	2,042	170	12	170		1,773	11
12	ASPHALT			2014	21,500	2,150	10	2,150		13,975	12
13	REMOVE AND REPLACE CARPETING IN ENTRYWAY			2014	9,800	1,225	8	1,225		7,554	13
14	WOOD PLANK VINYL & COVER BASE-ENTIRE FACILITY HALLWAY			2015	42,652	4,265	10	4,265		24,525	14
15	REMOVE WALLPAPER & PAINT HANDRAILS-ENTIRE FACILITY HALLWAY			2015	36,765	3,677	10	3,677		20,834	15
16											16
17	Home Office Depreciation					3,264		3,264			17
18											18
19	2011 IMPROVEMENTS (TI HILLSBORO)			2011	250,521	12,639	Various	12,639		147,591	19
20	2012 IMPROVEMENTS (TI HILLSBORO)			2012	58,858	2,792	Various	2,792		24,138	20
21	REMODEL SHOWER ON 300 HALL - TORN DOWN TO STUDS. ENLARGED			2016	53,119	3,541	15	3,541		17,411	21
22	WITH NEW PLUMBING, DRY WALL, TILE & PAINT										22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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	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 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)		\$ 2,948,696	\$ 96,887		\$ 96,887	\$	\$ 1,085,685	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	\$121,286	\$14,978	\$14,978	\$	Various	\$73,343	71	
72	Current Year Purchases							72	
73	Fully Depreciated Assets	325,187				Various	325,187	73	
74								74	
75	TOTALS	\$446,473	\$14,978	\$14,978	\$		\$398,530	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 Transport	Dodge Grand Caravan Conversion	2017	\$ 17,410	\$ 2,613	\$ 2,613	\$	5	\$ 9,286	76
77	Patient Transport	Dodge Caravan SE Minivan	2017	23,414	4,683	4,683		5	12,487	77
78										78
79										79
80	TOTALS			\$ 40,824	\$ 7,296	\$ 7,296	\$		\$ 21,773	80

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)				\$3,675,993	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$119,161	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$119,161	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$1,505,988	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress			
	Description	Cost	
92	Work in Progress	\$5,921	92
93			93
94			94
95		\$5,921	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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: \$ 3,415 Description: Dietary, Laundry, Housekeeping, Plant Copier (See WTB)
(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.

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.

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	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-03	hrs	\$	4,065	\$ 266,788	\$	4,065	\$ 266,788	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		638	50,956		638	50,956	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		3,186	196,144	530	3,186	196,674	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				108,750		108,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapy	V39-03			38	2,200		38	2,200	12
13	Other (specify): See WTB	V39-02,03				102,957	185,237		288,194	13
14	TOTAL			\$	7,927	\$ 619,045	\$ 294,517	7,927	\$ 913,562	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,610,845	\$ 1,618,988	1
2	Cash-Patient Deposits	103,737	103,737	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	471,129	471,179	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	167,525	169,965	6
7	Other Prepaid Expenses	375,597	376,262	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	395,933	558,711	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,124,766	\$ 3,298,842	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		240,000	13
14	Buildings, at Historical Cost		2,822,498	14
15	Leasehold Improvements, at Historical Cost	126,198	126,198	15
16	Equipment, at Historical Cost	49,920	487,297	16
17	Accumulated Depreciation (book methods)	(118,099)	(1,505,988)	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 Adjustment	(59,574)	(1,361,566)	22
23	Other(specify): WIP, Depr. Adjustment, Due to/f	23,039	175,412	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,484	\$ 983,851	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,146,250	\$ 4,282,693	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 745,799	\$ 745,799	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	103,737	103,737	28
29	Short-Term Notes Payable	499,788	499,788	29
30	Accrued Salaries Payable	169,620	169,620	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,260	40,260	31
32	Accrued Real Estate Taxes(Sch.IX-B)		41,902	32
33	Accrued Interest Payable		3,791	33
34	Deferred Compensation	912,999	912,999	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Rent/Mgmt Fees Payable	536,159	18,072	36
37	Prepaid Bed Tax	(17,647)	(17,647)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,990,715	\$ 2,518,321	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,568,604	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)	\$	\$ 1,568,604	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,990,715	\$ 4,086,925	46
47	TOTAL EQUITY(page 18, line 24)	\$ 155,535	\$ 195,768	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,146,250	\$ 4,282,693	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 191,438	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 191,438	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,903)	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)	\$ (35,903)	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)	\$ 155,535	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hillsboro Rehab HCC

0049221

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	\$ 4,637,331	1
2	Discounts and Allowances for all Levels	(1,614,741)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,022,590	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,384,382	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,384,382	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	(14,327)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	231,946	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	66,905	19
20	Radiology and X-Ray	14,846	20
21	Other Medical Services	74,129	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 373,499	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,926	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,926	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	273	28
28a	<u>COVID-19 PHE Funding</u>	394,678	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 394,951	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,179,348	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,026,730	31
32	Health Care	2,763,826	32
33	General Administration	1,425,669	33
	B. Capital Expense		
34	Ownership	773,981	34
	C. Ancillary Expense		
35	Special Cost Centers	984,000	35
36	Provider Participation Fee	241,045	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,215,251	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,903)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,903)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,025,573	44
45	Private Pay - Net Inpatient Revenue	1,081,780	45
46	Medicare - Net Inpatient Revenue	(1,083,277)	46
47	Other-(specify) <u>Managed Care</u>	(187,084)	47
48	Other-(specify) <u>Hospice</u>	185,598	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,022,590	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	1,081	1,097	\$ 48,847	\$ 44.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,474	8,965	290,922	32.45	3
4	Licensed Practical Nurses	23,924	25,695	668,436	26.01	4
5	CNAs & Orderlies	49,259	51,582	891,389	17.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	965	1,097	17,924	16.34	9
10	Activity Assistants	6,901	7,089	93,226	13.15	10
11	Social Service Workers	2,018	2,090	36,034	17.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,098	2,320	44,304	19.10	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,176	1,184	53,597	45.27	20
21	Assistant Administrator					21
22	Other Administrative	1,013	1,013	12,255	12.10	22
23	Office Manager					23
24	Clerical	11,189	11,895	124,484	10.47	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	970	1,122	12,520	11.16	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,944	2,080	44,218	21.26	33
34	TOTAL (lines 1 - 33)	111,012	117,229	\$ 2,338,156 *	\$ 19.95	34

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	Monthly	\$ 6,955	V01-3	35
36	Medical Director	Monthly	18,500	V10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,895	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	3,397	V11-3	44
45	Social Service Consultant	Monthly	2,458	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 40,205		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,103	\$ 80,980	V10-3	50
51	Licensed Practical Nurses	2,226	134,162	V10-3	51
52	Certified Nurse Assistants/Aides	5,773	232,673	V10-3	52
53	TOTAL (lines 50 - 52)	9,102	\$ 447,815		53

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

** See instructions.

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 \$8,276

(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? N/A

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,902 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. \$ 241,045
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? N/A
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.