

		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>0050971</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																							
Facility Name: <u>Lakeland 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>800 W Temple Avenue</u> <u>Effingham</u> <u>62401</u>																																																																																									
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Telephone Number: <u>(217) 342-2171</u> Fax # <u>(217) 342-2258</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, Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>7/1/2010</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, Suite 1800, St. Louis, MO 63101</u>	Date of Initial License for Current Owners: <u>7/1/2010</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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Facility Name & ID Number Lakeland Rehab HCC

0050971 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	156	Skilled (SNF)	156	57,096	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	156	TOTALS	156	57,096	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,311	8,464	7,666	31,441	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,311	8,464	7,666	31,441	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.07%

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 7/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 156 and days of care provided 6,560

Medicare Intermediary Wisconsin Physician 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 Lakeland Rehab HCC # 0050971 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		7,226	604,925	612,151		612,151		612,151			1
2	Food Purchase		18,049		18,049		18,049		18,049			2
3	Housekeeping		16,599	177,491	194,090		194,090		194,090			3
4	Laundry		12,878	117,317	130,195		130,195		130,195			4
5	Heat and Other Utilities			126,177	126,177		126,177		126,177			5
6	Maintenance	68,336	13,031	86,887	168,254		168,254		168,254			6
7	Other (specify):*											7
8	TOTAL General Services	68,336	67,783	1,112,797	1,248,916		1,248,916		1,248,916			8
	B. Health Care and Programs											
9	Medical Director			9,456	9,456		9,456		9,456			9
10	Nursing and Medical Records	2,765,382	137,575	29,985	2,932,942		2,932,942	(15,000)	2,917,942			10
10a	Therapy											10a
11	Activities	75,365	5,634	3,166	84,165		84,165		84,165			11
12	Social Services	68,010		2,712	70,722		70,722		70,722			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,908,757	143,209	45,319	3,097,285		3,097,285	(15,000)	3,082,285			16
	C. General Administration											
17	Administrative	130,422		390,867	521,289		521,289	25,875	547,164			17
18	Directors Fees											18
19	Professional Services			144,819	144,819		144,819	(52,828)	91,991			19
20	Dues, Fees, Subscriptions & Promotions			28,706	28,706		28,706	(4,712)	23,994			20
21	Clerical & General Office Expenses	176,829	37,725	180,278	394,832		394,832	(105,433)	289,399			21
22	Employee Benefits & Payroll Taxes			460,445	460,445		460,445		460,445			22
23	Inservice Training & Education			3,893	3,893		3,893		3,893			23
24	Travel and Seminar			1,814	1,814		1,814		1,814			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			209,127	209,127		209,127		209,127			26
27	Other (specify):*											27
28	TOTAL General Administration	307,251	37,725	1,419,949	1,764,925		1,764,925	(137,098)	1,627,827			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,284,344	248,717	2,578,065	6,111,126		6,111,126	(152,098)	5,959,028			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			40,817	40,817		40,817	212,854	253,671			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,795	2,795		2,795	250,049	252,844			32
33	Real Estate Taxes			86,135	86,135		86,135	19,778	105,913			33
34	Rent-Facility & Grounds			596,408	596,408		596,408	(596,408)				34
35	Rent-Equipment & Vehicles			2,970	2,970		2,970		2,970			35
36	Other (specify):* Mortgage Insurance Premium							56,264	56,264			36
37	TOTAL Ownership			729,125	729,125		729,125	(57,463)	671,662			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		536,558	848,651	1,385,209		1,385,209		1,385,209			39
40	Barber and Beauty Shops			779	779		779		779			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,439	235,439		235,439		235,439			42
43	Other (specify):* Marketing	49,559		33,971	83,530		83,530	(83,530)				43
44	TOTAL Special Cost Centers	49,559	536,558	1,118,840	1,704,957		1,704,957	(83,530)	1,621,427			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,333,903	785,275	4,426,030	8,545,208		8,545,208	(293,091)	8,252,117			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	(2,334)	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	(16,530)	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	(68,962)	21		24
25	Fund Raising, Advertising and Promotional	(25,486)	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	(63,697)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (177,009)		\$	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)	(116,082)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (116,082)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (293,091)		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	\$ (1,780)	20	1
2	Marketing Salaries	(49,559)	43	2
3	Marketing Benefit	(8,485)	43	3
4	Miscellaneous Income	(941)	21	4
5	IHCA Lobbying Portion of Dues	(2,932)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(63,697)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeland Rehab HCC# 0050971

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	25,875	0	0	0	0	0	0	0	0	25,875	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,692	(65,520)	0	0	0	0	0	0	0	0	(52,828)	19
20	Fees, Subscriptions & Promotions	(4,712)	0	0	0	0	0	0	0	0	0	0	(4,712)	20
21	Clerical & General Office Expenses	(86,433)	0	(19,000)	0	0	0	0	0	0	0	0	(105,433)	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	(91,145)	12,692	(58,645)	0	0	0	0	0	0	0	0	(137,098)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,145)	12,692	(73,645)	0	0	0	0	0	0	0	0	(152,098)	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	208,867	3,987	0	0	0	0	0	0	0	0	212,854	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,334)	255,178	(2,795)	0	0	0	0	0	0	0	0	250,049	32
33	Real Estate Taxes	0	19,778	0	0	0	0	0	0	0	0	0	19,778	33
34	Rent-Facility & Grounds	0	(596,408)	0	0	0	0	0	0	0	0	0	(596,408)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	56,264	0	0	0	0	0	0	0	0	0	56,264	36
37	TOTAL Ownership	(2,334)	(56,321)	1,192	0	0	0	0	0	0	0	0	(57,463)	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):*	(83,530)	0	0	0	0	0	0	0	0	0	0	(83,530)	43
44	TOTAL Special Cost Centers	(83,530)	0	0	0	0	0	0	0	0	0	0	(83,530)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(177,009)	(43,629)	(72,453)	0	0	0	0	0	0	0	0	(293,091)	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	\$ 596,408	TI-Effingham, LLC	100.00%	\$	\$ (596,408)	1
2	V	32	Interest		TI-Effingham, LLC	100.00%	248,757	248,757	2
3	V	19	A&G-Legal/Acctg/Small Equip		TI-Effingham, LLC	100.00%	12,692	12,692	3
4	V	36	Mortgage Insurance		TI-Effingham, LLC	100.00%	56,264	56,264	4
5	V	30	Depreciation		TI-Effingham, LLC	100.00%	208,867	208,867	5
6	V	32	Amortization of Financing Costs		TI-Effingham, LLC	100.00%	6,421	6,421	6
7	V	33	Real Estate Taxes	86,135	TI-Effingham, LLC	100.00%	105,913	19,778	7
8	V	26	Insurance	17,618	TI-Effingham, LLC	100.00%	17,618		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 700,161			\$ 656,532	\$ * (43,629)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1 Schedule V	2 Line	3	4	5	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22Insurance	\$3,985	CarePlus Health Plus		\$3,985	\$	15
16	V	22Insurance	139,097	Cost Plus Insurance		139,097		16
17	V	26Insurance	180,974	LTC Plus Insurance, Inc.		180,974		17
18	V	17Management-Operating	390,867	Tutera Health Care Service		416,742	25,875	18
19	V	19Management-Data Processing	65,520	Tutera Health Care Service			(65,520)	19
20	V	30Management-Depreciation		Tutera Health Care Service		3,987	3,987	20
21	V	10Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000)	21
22	V	21Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000)	22
23	V	32Interest	2,795	JCT Capital, LLC & Tutera Investments, LLC			(2,795)	23
24	V	06Plant & Maintenance	170	Walnut Creek Management Company, LLC		170		24
25	V	24Travel & Seminar	247	Walnut Creek Management Company, LLC		247		25
26	V	39Medical Supplies	78	Walnut Creek Management Company, LLC		78		26
27	V	19Purchased Svs/Data Processing	9,233	Walnut Creek Management Company, LLC		9,233		27
28	V	20Help Wanted Ads & Licenses	4,670	Walnut Creek Management Company, LLC		4,670		28
29	V	21Supplies, Sm Equip, Postage	8,000	Walnut Creek Management Company, LLC		8,000		29
30	V	10Pharmacy Consultant	9,758	Critical Care Rx, LLC		9,758		30
31	V	39Drugs	234,055	Critical Care Rx, LLC		234,055		31
32	V	39IV Therapy & Supplies	29,239	Critical Care Rx, LLC		29,239		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$1,112,688			\$1,040,235	\$*(72,453)	39

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

Facility Name & ID Number

Lakeland Rehab HCC

0050971

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 L	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			Auburn Rehab & Health Care Center	Auburn, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Seni	Aurora, IL	AL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Fox Lake, IL	AL	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 Lakeland Rehab HCC# 0050971 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	19	Management Fee- Operating	Direct Cost	287,210,821	71	\$ 15,078,459	\$ 10,830,799	7,938,049	\$ 416,745	1
2	30	Management Fee- Depreciation	Direct Cost	287,210,821	71	144,230		7,938,049	3,986	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		\$ 420,731	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			\$	8,513,870			\$ 248,757	1
2	HUD Amortize Financing Costs		X								6,421	2
3	Interest Income Offset										(2,334)	3
4												4
5												5
	Working Capital											
6												6
7	Tutera Investments, LLC	X		Working Capital - Note			647,058	52,819		0.0100	2,795	7
8	Related Party Offset										(2,795)	8
9	TOTAL Facility Related						\$ 647,058	\$ 8,566,689			\$ 252,844	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 647,058	\$ 8,566,689			\$ 252,844	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 56,264 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.		\$	103,347	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.)		\$	102,395	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(952)	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	106,865	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.		\$	105,913	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	93,229	8	
		2016	95,340	9	
		2017	97,387	10	
		2018	99,080	11	
		2019	102,395	12	
				13	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 Lakeland Rehab HCC COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0050971

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 03-11-020-019	Long-Term Care	\$ 102,395.06	\$ 102,395.06
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 102,395.06	\$ 102,395.06

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,594 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? ☐ YES ☐ NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Long-Term Care</u>	<u>28,594</u>	<u>2010</u>	<u>\$ 612,285</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>28,594</u>		<u>\$ 612,285</u>	<u>3</u>

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	156		2010	1971	\$ 5,081,962	\$ 184,799	27	\$ 184,799	\$	\$ 1,940,386	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2011 Building Improvements			2011	102,049	5,102	20	5,102		46,773	9
10	2012 Building Improvements			2012	17,065	853	10	853		15,572	10
11	2013 Building Improvements			2013	195,075	12,511	15	12,511		99,681	11
12	2016 Building Improvements			2016	9,945	493	7	493		8,898	12
13	Air Conditioning Unit			2017	6,184	380	7	380		5,233	13
14	400 HALL RENOVATION - Carpentry, Electrical, Dry Wall, Plumbing			2017	253,170	9,206	27	9,206		29,153	14
15											15
16	Asphalt Paving			2017	6,890	459	15	459		1,646	16
17	Fence Replacement			2020	18,097	503	15	503		503	17
18											18
19	2011 Building Improvements (TI Effingham)			2011	14,917		5			14,917	19
20	2012 Building Improvements (TI Effingham)			2012	157,941	5,743	27	5,743		47,861	20
21	400 HALL RENOVATION (TI EFFINGHAM) - Same as above just split			2017	32,258	1,173	27	1,173		4,008	21
22	New Front Door (TI Effingham)			2017	8,652	577	15	577		1,778	22
23	Concrete Parking Lot (TI Effingham)			2018	13,357	890	15	890		2,449	23
24											24
25	HOME OFFICE DEPRECIATION ALLOCATION					3,987		3,987			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)	\$ 5,917,562	\$ 226,676		\$ 226,676		\$ 2,218,858	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	\$220,977	\$24,929	\$24,929	\$	Various	\$128,454	71
72	Current Year Purchases	19,966	1,966	1,966		Various	1,966	72
73	Fully Depreciated Assets	515,845	100	100		Various	515,845	73
74								74
75	TOTALS	\$756,788	\$26,995	\$26,995	\$		\$646,265	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	Van	2012	\$ 57,587	\$	\$	\$		\$ 57,587	76
77										77
78										78
79										79
80	TOTALS			\$ 57,587	\$	\$	\$		\$ 57,587	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)			\$7,344,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$253,671	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$253,671	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)			\$2,922,710	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Work in Progress	\$69,413
93		
94		
95		\$69,413

* 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: \$2,970
- Description: Dietary, Laundry, 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.

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	\$	5,071	\$ 326,180	\$ 1,908	5,071	\$ 328,088	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		1,265	100,398		1,265	100,398	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		6,063	358,565	743	6,063	359,308	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				233,116		233,116	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				63,508	300,791		364,299	13
14	TOTAL			\$	12,399	\$ 848,651	\$ 536,558	12,399	\$ 1,385,209	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	\$ 490,532	\$ 577,700	1
2	Cash-Patient Deposits	40,784	40,784	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	594,195	594,195	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	214,275	220,191	6
7	Other Prepaid Expenses	509,758	541,520	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(553)	275,707	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,848,991	\$ 2,250,097	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		612,285	13
14	Buildings, at Historical Cost		5,309,088	14
15	Leasehold Improvements, at Historical Cost	608,475	608,475	15
16	Equipment, at Historical Cost	200,657	814,374	16
17	Accumulated Depreciation (book methods)	(339,186)	(2,922,710)	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	(22,273)	(52,188)	22
23	Other(specify): Other Assets - See WTB	565,692	790,428	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,013,365	\$ 5,159,752	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,862,356	\$ 7,409,849	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 803,791	\$ 803,791	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,784	40,784	28
29	Short-Term Notes Payable	52,819	52,819	29
30	Accrued Salaries Payable	243,943	243,943	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,698	40,698	31
32	Accrued Real Estate Taxes(Sch.IX-B)		106,865	32
33	Accrued Interest Payable		20,575	33
34	Deferred Compensation	1,203,411	1,203,411	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,385,446	\$ 2,512,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,513,870	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)	\$	\$ 8,513,870	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,385,446	\$ 11,026,756	46
47	TOTAL EQUITY(page 18, line 24)	\$ 476,910	\$ (3,616,907)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,862,356	\$ 7,409,849	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 791,784	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 791,784	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(314,874)	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)	\$ (314,874)	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)	\$ 476,910	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lakeland Rehab HCC

0050971

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	\$ 6,345,878	1
2	Discounts and Allowances for all Levels	(4,444,237)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,901,641	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,279,788	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,279,788	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	(5,862)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	445,448	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,830	19
20	Radiology and X-Ray	10,810	20
21	Other Medical Services	94,429	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 555,655	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,334	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,334	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	941	28
28a	<u>COVID-19 PHE Funding</u>	489,975	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 490,916	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,230,334	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,248,916	31
32	Health Care	3,097,285	32
33	General Administration	1,764,925	33
	B. Capital Expense		
34	Ownership	729,125	34
	C. Ancillary Expense		
35	Special Cost Centers	1,469,518	35
36	Provider Participation Fee	235,439	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,545,208	40
41	Income before Income Taxes (line 30 minus line 40)**	(314,874)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (314,874)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,036,098	44
45	Private Pay - Net Inpatient Revenue	1,286,102	45
46	Medicare - Net Inpatient Revenue	(1,670,609)	46
47	Other-(specify) <u>Managed Care</u>	245,976	47
48	Other-(specify) <u>Hospice</u>	4,075	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,901,642	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	1,912	2,080	\$ 110,314	\$ 53.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,039	21,670	655,130	30.23	3
4	Licensed Practical Nurses	27,302	29,413	764,164	25.98	4
5	CNAs & Orderlies	69,177	73,344	1,201,855	16.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,689	1,865	27,411	14.70	9
10	Activity Assistants	4,398	4,558	47,954	10.52	10
11	Social Service Workers	3,578	3,917	68,010	17.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,763	4,010	68,336	17.04	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,896	2,080	130,422	62.70	20
21	Assistant Administrator					21
22	Other Administrative	527	587	6,082	10.36	22
23	Office Manager					23
24	Clerical	10,467	11,392	176,829	15.52	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	1,916	2,062	27,837	13.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,047	2,259	49,559	21.94	33
34	TOTAL (lines 1 - 33)	148,711	159,237	\$ 3,333,903 *	\$ 20.94	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	Monthly	\$ 12,256	V01-3	35
36	Medical Director	Monthly	9,456	V09-3	36
37	Medical Records Consultant	Monthly	1,793	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,758	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	2,722	V11-3	44
45	Social Service Consultant	Monthly	2,712	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,697		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

