

		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>0046276</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																							
Facility Name: <u>Metropolis 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>2299 Metropolis St</u> <u>Metropolis</u> <u>62960</u>																																																																																									
Number City Zip Code																																																																																									
County: <u>Massac</u>																																																																																									
Telephone Number: <u>(618) 524-2634</u> Fax # <u>(618) 524-2507</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>7/1/2003</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>7/1/2003</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 Metropolis Rehab HCC

0046276 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	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,966</u>	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	<u>101</u>	TOTALS	<u>101</u>	<u>36,966</u>	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	<u>12,231</u>	<u>3,957</u>	<u>4,857</u>	<u>21,045</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,231</u>	<u>3,957</u>	<u>4,857</u>	<u>21,045</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.93%

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 7/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/2003 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 101 and days of care provided 3,234

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Metropolis Rehab HCC # 0046276 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		20,466	367,604	388,070		388,070		388,070			1
2	Food Purchase		11,091		11,091		11,091		11,091			2
3	Housekeeping		10,339	95,459	105,798		105,798		105,798			3
4	Laundry		4,541	63,397	67,938		67,938		67,938			4
5	Heat and Other Utilities			168,820	168,820		168,820		168,820			5
6	Maintenance	63,830	13,714	41,594	119,138		119,138		119,138			6
7	Other (specify):*											7
8	TOTAL General Services	63,830	60,151	736,874	860,855		860,855		860,855			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,498,618	92,832	36,576	1,628,026		1,628,026	(15,000)	1,613,026			10
10a	Therapy											10a
11	Activities	60,542	10,601	7,320	78,463		78,463		78,463			11
12	Social Services	34,186		3,370	37,556		37,556		37,556			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,593,346	103,433	53,266	1,750,045		1,750,045	(15,000)	1,735,045			16
	C. General Administration											
17	Administrative	92,846		236,431	329,277		329,277	16,185	345,462			17
18	Directors Fees											18
19	Professional Services			83,397	83,397		83,397	(24,256)	59,141			19
20	Dues, Fees, Subscriptions & Promotions			16,817	16,817		16,817	(2,348)	14,469			20
21	Clerical & General Office Expenses	97,245	21,834	152,678	271,757		271,757	(101,077)	170,680			21
22	Employee Benefits & Payroll Taxes			239,646	239,646		239,646		239,646			22
23	Inservice Training & Education			2,727	2,727		2,727		2,727			23
24	Travel and Seminar			3,814	3,814		3,814		3,814			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			129,242	129,242		129,242		129,242			26
27	Other (specify):*											27
28	TOTAL General Administration	190,091	21,834	864,752	1,076,677		1,076,677	(111,496)	965,181			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,847,267	185,418	1,654,892	3,687,577		3,687,577	(126,496)	3,561,081			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			19,162	19,162		19,162	121,559	140,721			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,943	39,943		39,943	35,817	75,760			32
33	Real Estate Taxes			30,452	30,452		30,452	801	31,253			33
34	Rent-Facility & Grounds			271,700	271,700		271,700	(271,700)				34
35	Rent-Equipment & Vehicles			14,222	14,222		14,222		14,222			35
36	Other (specify):* Mortgage Insurance Premium							16,925	16,925			36
37	TOTAL Ownership			375,479	375,479		375,479	(96,598)	278,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		265,605	546,299	811,904		811,904		811,904			39
40	Barber and Beauty Shops		247	19	266		266		266			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,769	163,769		163,769		163,769			42
43	Other (specify):* Marketing	66,786		36,683	103,469		103,469	(103,469)				43
44	TOTAL Special Cost Centers	66,786	265,852	746,770	1,079,408		1,079,408	(103,469)	975,939			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,914,053	451,270	2,777,141	5,142,464		5,142,464	(326,563)	4,815,901			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	(2,106)	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	(10,724)	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	(71,880)	21		24
25	Fund Raising, Advertising and Promotional	(25,391)	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	(79,899)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190,000)		\$	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)	(136,563)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (136,563)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (326,563)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Portion of Dues	\$ (1,898)	20	1
2	Marketing Salaries	(66,786)	43	2
3	Marketing Benefits	(11,292)	43	3
4	Misc Income/Expense	527	21	4
5	Chamber of Commerce Dues	(450)	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	(79,899)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Metropolis Rehab HCC# 0046276

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	16,185	0	0	0	0	0	0	0	0	16,185	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,020	(33,276)	0	0	0	0	0	0	0	0	(24,256)	19
20	Fees, Subscriptions & Promotions	(2,348)	0	0	0	0	0	0	0	0	0	0	(2,348)	20
21	Clerical & General Office Expenses	(82,077)	0	(19,000)	0	0	0	0	0	0	0	0	(101,077)	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	(84,425)	9,020	(36,091)	0	0	0	0	0	0	0	0	(111,496)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,425)	9,020	(51,091)	0	0	0	0	0	0	0	0	(126,496)	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	119,142	2,417	0	0	0	0	0	0	0	0	121,559	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,106)	77,866	(39,943)	0	0	0	0	0	0	0	0	35,817	32
33	Real Estate Taxes	0	801	0	0	0	0	0	0	0	0	0	801	33
34	Rent-Facility & Grounds	0	(271,700)	0	0	0	0	0	0	0	0	0	(271,700)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	16,925	0	0	0	0	0	0	0	0	0	16,925	36
37	TOTAL Ownership	(2,106)	(56,966)	(37,526)	0	0	0	0	0	0	0	0	(96,598)	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):*	(103,469)	0	0	0	0	0	0	0	0	0	0	(103,469)	43
44	TOTAL Special Cost Centers	(103,469)	0	0	0	0	0	0	0	0	0	0	(103,469)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(190,000)	(47,946)	(88,617)	0	0	0	0	0	0	0	0	(326,563)	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	\$ 271,700	TI - Metropolis	100.00%	\$	(271,700)	1
2	V	32	Interest		TI - Metropolis	100.00%	77,588	77,588	2
3	V	19	Legal/Accounting		TI - Metropolis	100.00%	9,020	9,020	3
4	V	36	Mortgage Insurance		TI - Metropolis	100.00%	16,925	16,925	4
5	V	30	Depreciation		TI - Metropolis	100.00%	119,142	119,142	5
6	V	32	Amortization of Financing Costs		TI - Metropolis	100.00%	278	278	6
7	V	33	Real Estate Taxes	30,452	TI - Metropolis	100.00%	31,253	801	7
8	V	26	Insurance Property	9,364	TI - Metropolis	100.00%	9,364		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 311,516			\$ 263,570	\$ * (47,946)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Insurance	\$ 3,042	CarePlus Health Plus		\$ 3,042	\$	15
16	V	22	Insurance	59,735	Cost Plus Insurance		59,735		16
17	V	26	Insurance	117,169	LTC Plus Insurance, Inc.		117,169		17
18	V	17	Management-Operating	236,431	Tutera Health Care Service		252,616	16,185	18
19	V	19	Management-Data Processing	33,276	Tutera Health Care Service			(33,276)	19
20	V	30	Management-Depreciation		Tutera Health Care Service		2,417	2,417	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	39,943	Tutera Investments			(39,943)	23
24	V	11	Activities - Supplies	139	Walnut Creek Management Company, LLC		139		24
25	V	24	Travel & Seminar	3,048	Walnut Creek Management Company, LLC		3,048		25
26	V	43	Marketing	271	Walnut Creek Management Company, LLC		271		26
27	V	19	Purchased Svs/Data Processing	7,780	Walnut Creek Management Company, LLC		7,780		27
28	V	20	Help Wanted Ads & Licenses	2,168	Walnut Creek Management Company, LLC		2,168		28
29	V	21	Supplies, Sm Equip, Postage	5,676	Walnut Creek Management Company, LLC		5,676		29
30	V	10	Nursing Admin - Supplies	201	Walnut Creek Management Company, LLC		201		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 542,879			\$ 454,262	\$ * (88,617)	39

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

Facility Name & ID Number

Metropolis Rehab HCC

0046276

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.	100%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2			Bethany Rehab & Health Care Center	DeKalb, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3			Carlinville Rehab & Health Care Center	Carlinville, 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			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			Auburn Rehab & Health Care Center	Auburn, 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 Metropolis Rehab HCC# 0046276 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 Costs	287,210,821	71	\$ 15,078,459	\$ 10,830,799	4,811,757	\$ 252,615	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		4,811,757	2,416	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		\$ 255,031	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			\$		\$ 3,062,144			\$ 77,588	1
2	HUD Financing Costs		X									278	2
3	Interest Income Offset - TI Metropolis											(130)	3
4	Interest Income Offset - Metropolis											(2,106)	4
5													5
	Working Capital												
6													6
7	Tutera Investments	X		Note Payable				4,389,086	3,789,029		0.0100	39,943	7
8	Related Party Offset											(39,943)	8
9	TOTAL Facility Related						\$ 4,389,086	\$ 6,851,173			\$ 75,630	9	
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,389,086	\$ 6,851,173			\$ 75,630	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,925 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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Metropolis Rehab HCC COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0046276

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. 05-36-300-006	Long-Term Care	\$ 31,483.62	\$ 31,483.62
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 31,483.62	\$ 31,483.62

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:35,128

B. General Construction Type:ExteriorBrickFrameBlock

Number of Stories1

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long-Term Care	35,128	2003	\$285,485	1
2					2
3	TOTALS	35,128		\$285,485	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	101		2003	1965	\$ 2,226,787	\$ 55,670	40	\$ 55,670	\$	\$ 974,219	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2003 IMPROVEMENTS			2003	2,869					2,869	9
10	2004 IMPROVEMENTS			2004	43,387	1,720	Various	1,720		36,794	10
11	2005 IMPROVEMENTS			2005	152,444					152,444	11
12	2006 IMPROVEMENTS			2006	2,795					2,795	12
13	2007 IMPROVEMENTS			2007	2,132					2,132	13
14	2012 IMPROVEMENTS			2012	229,200	11,460	Various	11,460		210,100	14
15	ASBESTOS ABATEMENT			2017	19,910	724	27	724		2,534	15
16	ROOF REPLACEMENT SECTIONS A&B			2018	85,002	3,100	27	3,100		6,717	16
17	2009 IMPROVEMENTS (TI METROPOLIS)			2009	19,997					19,997	17
18	2010 IMPROVEMENTS (TI METROPOLIS)			2010	61,778	3,483	Various	3,483		61,472	18
19	2011 IMPROVEMENTS (TI METROPOLIS)			2011	33,600	1,953	Various	1,953		18,873	19
20	2012 IMPROVEMENTS (TI METROPOLIS)			2012	38,438	1,922	20	1,922		16,496	20
21	2013 IMPROVEMENTS (TI METROPOLIS)			2013	162,449	10,830	10	10,830		82,040	21
22	EXTERIOR PAINTING (TI METROPOLIS)			2015	7,370	1,053	7	1,053		5,615	22
23	ROOFTOP HVAC (TI METROPOLIS)			2016	16,995	1,700	10	1,700		7,365	23
24	DOORS & FRAMES MAIN, SERVICE, & EMPL ENTR (TI METROPOLIS)			2016	9,842	656	15	656		2,898	24
25	HOT WATER HEATER STORAGE TANK (TI METROPOLIS)			2016	43,135	2,157	20	2,157		9,346	25
26	ENTRANCE CANOPY (TI METROPOLIS)			2016	9,185	312	15	312		2,551	26
27	WATER SOFTENING SYSTEM (TI METROPOLIS)			2016	5,760	576	10	576		2,448	27
28	POOL HEATER PUMP (TI METROPOLIS)			2016	5,192	742	7	742		3,214	28
29	HVAC SYSTEM (TI METROPOLIS)			2017	262,828	26,283	10	26,283		87,610	29
30											30
31											31
32	HOME OFFICE DEPRECIATION					2,417		2,417			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)		\$ 3,441,095	\$ 126,758		\$ 126,758	\$	\$ 1,710,529	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	\$140,921	\$12,798	\$12,798	\$	Various	\$65,081	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	579,952	580	580		Various	579,952	73
74								74
75	TOTALS	\$720,873	\$13,378	\$13,378	\$		\$645,033	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	Ford Goshen Bus	2015	\$43,709	\$585	\$585	\$	5	\$43,709	76
77										77
78										78
79										79
80	TOTALS			\$43,709	\$585	\$585	\$		\$43,709	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)	\$4,491,162	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$140,721	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$140,721	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)	\$2,399,271	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	WIP - Reserves	\$11,000	92
93			93
94			94
95		\$11,000	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.

		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:
- YESNO
- Terms:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$14,222Description: Dietary, Laundry, Plant, Copier, Nursing (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.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-03	hrs	\$	3,048	\$ 235,602	\$	3,048	\$ 235,602	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		913	69,382		913	69,382	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		2,576	188,390	251	2,576	188,641	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				86,014		86,014	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				52,925	179,340		232,265	13
14	TOTAL			\$	6,537	\$ 546,299	\$ 265,605	6,537	\$ 811,904	14

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

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 98,603	\$ 111,007	1
2	Cash-Patient Deposits	39,804	39,804	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	754,679	754,679	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,112	141,257	6
7	Other Prepaid Expenses	279,851	285,659	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		300,069	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,311,049	\$ 1,632,475	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		285,485	13
14	Buildings, at Historical Cost		2,903,357	14
15	Leasehold Improvements, at Historical Cost	537,738	537,738	15
16	Equipment, at Historical Cost	214,644	764,582	16
17	Accumulated Depreciation (book methods)	(593,507)	(2,399,271)	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	(10,923)	(1,558,960)	22
23	Other(specify): Other Assets	413,803	422,132	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 561,755	\$ 955,063	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,872,804	\$ 2,587,538	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 489,683	\$ 489,683	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,804	39,804	28
29	Short-Term Notes Payable	3,789,029	3,789,029	29
30	Accrued Salaries Payable	100,060	100,060	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,389	28,389	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,484	32
33	Accrued Interest Payable		6,379	33
34	Deferred Compensation	703,038	703,038	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Management Fees Payable	5,399	5,399	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,155,402	\$ 5,193,265	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,062,144	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)	\$	\$ 3,062,144	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,155,402	\$ 8,255,409	46
47	TOTAL EQUITY (page 18, line 24)	\$ (3,282,598)	\$ (5,667,871)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,872,804	\$ 2,587,538	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,189,278)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,189,278)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(93,320)	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)	\$ (93,320)	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)	\$ (3,282,598)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Metropolis Rehab HCC

0046276

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,113,205	1
2	Discounts and Allowances for all Levels	(1,436,151)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,677,054	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,851,737	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,851,737	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	(1,423)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	175,584	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,467	19
20	Radiology and X-Ray	5,532	20
21	Other Medical Services	33,097	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 231,257	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,106	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,106	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(527)	28
28a	COVID-19 PHE Funding	287,517	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 286,990	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,049,144	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	860,855	31
32	Health Care	1,750,045	32
33	General Administration	1,076,677	33
	B. Capital Expense		
34	Ownership	375,479	34
	C. Ancillary Expense		
35	Special Cost Centers	915,639	35
36	Provider Participation Fee	163,769	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,142,464	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,320)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,320)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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	1,984	2,080	\$ 103,355	\$ 49.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,814	12,518	391,768	31.30	3
4	Licensed Practical Nurses	13,758	14,873	353,077	23.74	4
5	CNAs & Orderlies	44,865	46,775	624,140	13.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,786	1,838	30,600	16.65	9
10	Activity Assistants	2,583	2,602	29,942	11.51	10
11	Social Service Workers	1,959	2,103	34,186	16.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,933	3,260	63,830	19.58	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,928	2,080	92,846	44.64	20
21	Assistant Administrator					21
22	Other Administrative	999	999	12,429	12.44	22
23	Office Manager					23
24	Clerical	6,558	6,905	97,245	14.08	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	1,048	1,148	13,849	12.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,904	2,080	66,786	32.11	33
34	TOTAL (lines 1 - 33)	94,119	99,261	\$ 1,914,053 *	\$ 19.28	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	\$ 7,780	V01-3	35
36	Medical Director	Monthly	6,000	V09-3	36
37	Medical Records Consultant	Monthly	1,645	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	7,508	V10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,376	V11-3	44
45	Social Service Consultant	Monthly	3,370	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,679		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

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 \$6,908

(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? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,957 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. \$ 163,769
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.