

		FOR BHF USE						

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>1/1/2025</u> to <u>12/31/2025</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: _____																											
Date of Initial License for Current Owners: <u>7/1/2003</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																									
☐ Charitable Corp.	☐ Individual	☐ State																									
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																									
	☐ "Sub-S" Corp.	_____																									
	☒ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											

STATE OF ILLINOIS

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Facility Name & ID NumberMetropolis Rehab HCC# 0046276Report Period Beginning: 1/1/2025Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

1	2	3	4
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1	101	101	36,865
2	Skilled (SNF)		
3	Skilled Pediatric (SNF/PED)		
4	Intermediate (ICF)		
5	Intermediate/DD		
6	Sheltered Care (SC)		
7	ICF/DD 16 or Less		
101	TOTALS	101	36,865

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9
Level of Care	Patient Days by Level of Care and Primary Source of Payment							
	Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total
			Medicaid Primary	Medicare Primary				
8	SNF	5,958	4,695	5,736	6,356	2,408	2,181	27,334
9	SNF/PED							
10	ICF							
11	ICF/DD							
12	SC							
13	DD 16 OR LESS							
14	TOTALS	5,958	4,695	5,736	6,356	2,408	2,181	27,334

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

74.15%

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?

YESNO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YESNO

I. On what date did you start providing long term care at this location?

Date started7/1/2003

J. Was the facility purchased or leased after January 1, 1978?

YESDate7/1/2003NO

K. Was the facility certified for Medicare during the reporting year?

YESNO

If YES, enter certified beds.

number of certified beds101

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUALMODIFIEDCASH*

Is your fiscal year identical to your tax year?

YESNO

Tax Year:12/31/2025Fiscal Year:12/31/2025

* All facilities other than governmental must report on the accrual basis.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	255,276	33,731	73,626	362,633		362,633	(1,631)	361,002		1
2	Food Purchase		281,749		281,749		281,749		281,749		2
3	Housekeeping		11,086	134,500	145,586		145,586		145,586		3
4	Laundry		3,863	89,666	93,529		93,529		93,529		4
5	Heat and Other Utilities			133,675	133,675		133,675		133,675		5
6	Maintenance	60,467	22,923	136,489	219,879		219,879		219,879		6
7	Other (specify):*										7
8	TOTAL General Services	315,743	353,352	567,956	1,237,051		1,237,051	(1,631)	1,235,420		8
	B. Health Care and Programs										
9	Medical Director			28,079	28,079		28,079		28,079		9
10	Nursing and Medical Records	2,139,501	108,690	492,931	2,741,122		2,741,122		2,741,122		10
10a	Therapy										10a
11	Activities	81,198	10,413	10,400	102,011		102,011		102,011		11
12	Social Services	48,365		3,200	51,565		51,565		51,565		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,269,064	119,103	534,610	2,922,777		2,922,777		2,922,777		16
	C. General Administration										
17	Administrative	111,328		337,811	449,139		449,139	23,010	472,149		17
18	Directors Fees										18
19	Professional Services			140,683	140,683		140,683	(41,395)	99,288		19
20	Dues, Fees, Subscriptions & Promotions			22,517	22,517		22,517	(3,786)	18,731		20
21	Clerical & General Office Expenses	160,135	23,824	1,116,870	1,300,829		1,300,829	22,464	1,323,293		21
22	Employee Benefits & Payroll Taxes			365,885	365,885		365,885		365,885		22
23	Inservice Training & Education			4,427	4,427		4,427		4,427		23
24	Travel and Seminar			4,176	4,176		4,176	494	4,670		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			100,346	100,346		100,346		100,346		26
27	Other (specify):*										27
28	TOTAL General Administration	271,463	23,824	2,092,715	2,388,002		2,388,002	787	2,388,789		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,856,270	496,279	3,195,281	6,547,830		6,547,830	(844)	6,546,986		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
		1	2	3	4	5	6	7	8		
30	D. Ownership			20,916	20,916		20,916	137,282	158,198		30
31	Depreciation										31
32	Amortization of Pre-Op. & Org.			38,627	38,627		38,627	26,034	64,661		32
33	Interest			30,466	30,466		30,466		30,466		33
34	Real Estate Taxes			243,225	243,225		243,225	(243,225)			34
35	Rent-Facility & Grounds			3,508	3,508		3,508	301	3,809		35
36	Rent-Equipment & Vehicles							14,131	14,131		36
36	Other (specify):* Mortgage Ins										
37	TOTAL Ownership			336,742	336,742		336,742	(65,477)	271,265		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		50,830	759,470	810,300		810,300		810,300		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee										42
43	Other (specify):*	74,211		77,347	151,558		151,558	(579,817)	(428,259)		43
44	TOTAL Special Cost Centers	74,211	50,830	836,817	961,858		961,858	(579,817)	382,041		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,930,481	547,109	4,368,840	7,846,430		7,846,430	(646,138)	7,200,292		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,631)	1		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	154	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	(23,465)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(417,041)	43		24
25	Fund Raising, Advertising and Promotional	(19,859)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(42,568)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (504,410)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(141,728)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (141,728)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (646,138)		37

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

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

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

Report Period Beginning:

Ending:

ID#

0046276

1/1/2025

12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ (3,863)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Marketing Salaries	(74,211)	43	3
4	Marketing Benefits	(11,218)	43	4
5	Misc Income/Expense	45,929	21	5
6				6
7	Storage Rental	301	35	7
8	Transportation	494	24	8
9				9
10				10
11				11
12				12
13				13
14				14
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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	(42,568)		49

VII. RELATED PARTIES

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

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

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	\$ 243,225	TI - Metropolis	100.00%	\$	(243,225)	1
2	V	32	Interest		TI - Metropolis	100.00%	64,229	64,229	2
3	V	19	Legal/Accounting/Professional Svcs		TI - Metropolis	100.00%	10,173	10,173	3
4	V	36	Mortgage Insurance		TI - Metropolis	100.00%	14,131	14,131	4
5	V	30	Depreciation		TI - Metropolis	100.00%	126,036	126,036	5
6	V	32	Amortization of Financing Costs		TI - Metropolis	100.00%	278	278	6
7	V	33	Real Estate Taxes	30,466	TI - Metropolis	100.00%	30,466		7
8	V	26	Property Insurance	19,165	TI - Metropolis	100.00%	19,165		8
9	V	20	Licenses		TI - Metropolis	100.00%	77	77	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 292,856			\$ 264,555	\$ * (28,301)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 Management-Operating	\$ 337,811	Tutera Health Care Service		\$ 360,821	\$ 23,010	15
16	V	19 Management-Data Processing	51,568	Tutera Health Care Service			(51,568)	16
17	V	30 Management-Depreciation		Tutera Health Care Service		11,246	11,246	17
18	V	43 Management-Marketing	57,488	Tutera Health Care Service			(57,488)	18
19	V	32 Interest	38,627	Tutera Investments			(38,627)	19
20	V	26 Insurance	78,012	LTC Plus Insurance, Inc.		78,012		20
21	V	10 Nursing Purchased Services	15,275	TeamWorkers LLC		15,275		21
22	V	10 Pharmacy Consultant	6,520	United Rx		6,520		22
23	V	10 Nursing Purch Sves, Med Supplies	3,663	United Rx		3,663		23
24	V	39 IV Therapy & Supplies	435	United Rx		435		24
25	V	39 Drugs	167,576	United Rx		167,576		25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 756,975			\$ 643,548	\$ * (113,427)	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Bethany Rehab & Health Care Center	Dekalb, IL			Antioch Valley	Overland Park, KS	AL	1
2	Carlinsville Rehab & Health Care Center	Carlinsville, IL			Carnegie Village Senior	Belton, MO	IL/AL	2
3	Carnegie Village Rehab & Health Care Center	Belton, MO			Country Gardens Assisted	Muskogee, OK	AL	3
4	Charlton Place Rehab & Health Care Center	Deatsville, AL			Laurel Assisted Living	Liberty, MO	AL	4
5	Coulterville Rehab & Health Care Center	Coulterville, IL			Missiona Chateau Senior	Prairie Village, KS	AL/IL	5
6	Crystal Pines Rehab & Health Care Center	Crystal Lake, IL			Oakley Court Assisted	Freeport, IL	AL	6
7	Dixon Rehab & Health Care Center	Dixon, IL			Town Center	Overland Park, KS	AL	7
8	Estoria Rehabilitation	Liberty, MO			Stratford Commons Memory	Overland Park, KS	Memory Care	8
9	Fair Oaks Rehab & Health Care Center	South Beloit, IL			The Lodge at Manito	Manito, IL	AL	9
10	Grand Meadows Senior Living	Asbury, IA			Tiffany Springs SLC	Kansas City, MO	AL/IL	10
11	Highland Rehab & Health Care Center	Kansas City, MO			Wesley Court Assisted	Boling Springs, SC	AL	11
12	Hillsboro Rehab & Health Care Center	Hillsboro, IL						12
13	Lakeland Rehab & Health Care Center	Effingham, IL						13
14	Matton Rehab & Health Care Center	Mattoon IL						14
15	Meridian Rehab & Health Care Center	Wichita, KS			LTC Plus Insurance LLC	Kansas City, MO	Insurance Company	15
16	Monterey Park Rehab & Health Care Center	Independence, MO			JCT Capital, Inc.	Kansas City, MO	Mgmt Company	16
17	Montgomery Children's Specialty Center	Montgomery, AL			Tutera Group, Inc.	Kansas City, MO	Mgmt Company	17
18	Moweaqua Rehab & Health Care Center	Moweaqua, IL			Tutera Health Care Services	Kansas City, MO	Mgmt Company	18
19	Northland Rehab & Health Care Center	Kansas City, MO			Tutera Investments, LLC	Kansas City, MO	Mgmt Company	19
20	St. Paul's Senior Community	Belleville, IL			Walnut Creek Mgmt LLC	Kansas City, MO	Mgmt Company	20
21	Stratford Rehab & Health Care Center	Overland Park, KS			Walnut Creek New Enterprises	Kansas City, MO	Mgmt Company	21
22	The Village at Mission	Prairie Village, KS			IPM, Inc.	Kansas City, MO	Property Mgt	22
23	Tiffany Springs Rehab & Health Care Center	Kansas City, MO			Columbia 7611 LLC	Kansas City, MO	Building Company	23
24	Westview of Derby Rehab & Health Care Center	Derby, KS			JCT FLP Auburn LLC	Aurora, IL	Building Company	24
25	Windsor Estates of St. Charles	St. Charles, MO			TeamWorkers LLC	Kansas City, MO	Agency Nursing	25
26	Holly Hill Rehab & Health Care Center	Sulphur, LA			Critical Care Rx, LLC	Kansas City, MO	Pharmacy Company	26
27	Rosewood Rehab & Health Care Center	Lake Charles, LA						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.

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.)

YESXNO

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

Name of Related OrganizationTutera Health Care Services
Street Address7611 State Line Road
City / State / Zip CodeKansas City, Missouri 64114
Phone Number(816) 444-0900
Fax Number(816) 822-0081

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fee Operating	Direct Cost	512,439,158	114	\$ 24,349,098	\$ 16,637,381	7,593,605	360,818	1
2	30	Management Fee Depreciation	Direct Cost	512,439,158	114	758,922		7,593,605	11,246	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					\$ 25,108,020	\$ 16,637,381		\$ 372,064	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 (Landlord WTB)		X	Mortgage			\$		\$	2,516,751						\$	64,229		1	
2	HUD Financing Costs		X														278		2	
3	Interest Income Offset - Metropolis																154		3	
4																			4	
5																			5	
	Working Capital																			
6	Tutera Investments	X		Note Payable				4,389,086		4,247,024						0.0100		38,627		6
7	Related Party Offset																	(38,627)		7
8																			8	
9	TOTAL Facility Related						\$	4,389,086	\$	6,763,775						\$	64,661		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	\$	6,763,775						\$	64,661		15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 14,131 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 2024 report.		\$	33,474	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.)		\$	31,970	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,504)	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	31,970	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.		\$	30,466	7	
Assessed Value from Real Estate Tax Bill:	2024	34,070	8		
Real Estate Tax Bill for Calendar Year:	2020	31,800	9		
	2021	32,604	10		
	2022	32,880	11		
	2023	33,475	12		
	2024	31,970	13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION\$ 17

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

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

FACILITY NAME Metropolis Rehab HCC COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0046276

CONTACT PERSON REGARDING THIS REPORT Fatima Sediqzad

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)		(B)		(C)		(D)	
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>	
1.	05-36-300-006		Long Term Care	\$	31,970.34	\$	31,970.34
2.				\$		\$	
3.				\$		\$	
4.				\$		\$	
5.				\$		\$	
6.				\$		\$	
7.				\$		\$	
8.				\$		\$	
9.				\$		\$	
10.				\$		\$	
TOTALS				\$	31,970.34	\$	31,970.34

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?

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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:

Exterior

Brick

Frame

Brick

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. 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.

K. 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:

	1	2	3	4	
A. Land.	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		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	101		2003	1965	\$ 2,226,787	\$ 55,670	40	\$ 55,670		\$ 1,252,567	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					43,387	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					229,200	14
15	ASBESTOS ABATEMENT			2017	19,910	724	27	724		6,154	15
16	ROOF REPLACEMENT SECTIONS A&B			2018	85,002	3,100	27	3,100		22,219	16
17	New Service Doors			2021	5,323	532	10	532		2,351	17
18	Dining and Walk-in Remodel (Vinyl Flooring, Drywall Repair, Painting)			2025	47,040	784	20	784		784	18
19	Flooring			2021	80,089	5,339	15	5,339		19,132	19
20	2009 IMPROVEMENTS (TI METROPOLIS)			2009	19,997					19,997	20
21	2010 IMPROVEMENTS (TI METROPOLIS)			2010	61,778	44	Various	44		61,778	21
22	2011 IMPROVEMENTS (TI METROPOLIS)			2011	33,600	1,703	Various	1,703		27,390	22
23	2012 IMPROVEMENTS (TI METROPOLIS)			2012	38,438	1,922	20	1,922		26,106	23
24	2013 IMPROVEMENTS (TI METROPOLIS)			2013	162,449	10,830	10	10,830		136,190	24
25	2015 IMPROVEMENTS (TI METROPOLIS)			2015	7,370					7,370	25
26	2016 IMPROVEMENTS (TI METROPOLIS)			2016	90,108	5,701	Various	5,701		58,303	26
27	HVAC SYSTEM (TI METROPOLIS)			2017	262,828	26,283	10	26,283		219,025	27
28	INTERIOIR RENOVATIONS			2022	96,620	9,505	10	9,505		35,433	28
29	Vestibule 400 Hall - paint entry space - walls & door trim										29
30	400 Hall - Fix drywall, paint & replace water damaged ceiling tiles										30
31	100 & 200 Hall Lounge - Replace ceiling/fix drywall & paint walls & door trim										31
32	Beauty Salon - Fix drywall, paint & replace ceiling tiles										32
33	400 Hall Restrooms (x9) - fix drywall, paint & replace water damaged ceiling tiles										33
34	& replace 1 toilet with ADA toilet										34
35	HOME OFFICE DEPRECIATION					11,246		11,246			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

1	2	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)		\$3,670,166	\$133,383		\$133,383	\$	\$2,327,626	70

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

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	\$204,462	\$19,432	\$19,432			\$141,338	71
72	Current Year Purchases	19,000	905	905			905	72
73	Fully Depreciated Assets	592,396					592,396	73
74								74
75	TOTALS	\$815,858	\$20,337	\$20,337	\$		\$734,639	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	\$ 2,778	\$ 2,778	\$	5	\$ 43,709	76
77	Patient Transport	Van Engine	2023	8,500	1,700	1,700		5	3,825	77
78										78
79										79
80	TOTALS			\$ 52,209	\$ 4,478	\$ 4,478	\$		\$ 47,534	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)			\$4,823,718
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$158,198
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$158,198
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$3,109,799

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

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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?
16. Rental Amount for movable equipment: \$ 3,508 Description: Nursing, Dietary, Dishwasher, & Copier (See WTB)
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
Fiscal Year EndingAnnual Rent
12. /2026 \$
13. /2027 \$
14. /2028 \$

* 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.)

	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	2	3	
1	Licensed Occupational Therapist	V39-03	hrs	\$	2,154	\$ 201,594	\$	2,154	\$ 201,594	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		474	66,766		474	66,766	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-02,03	hrs		2,364	245,766	927	2,364	246,693	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			154,916	56		154,972	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	V39-03					7,159		7,159	12
13	Other (specify): <u>See WTB</u>	V39-02,03				90,428	42,688		133,116	13
14	TOTAL			\$	4,992	\$ 759,470	\$ 50,830	4,992	\$ 810,300	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 21,450	\$ 35,509	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	561,993	561,993	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,249	84,157	6
7	Other Prepaid Expenses	223,072	227,712	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	78,337	227,575	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 959,101	\$ 1,136,946	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		2,999,977	14
15	Leasehold Improvements, at Historical Cost	670,190	670,190	15
16	Equipment, at Historical Cost	258,291	868,066	16
17	Accumulated Depreciation (book methods)	(705,073)	(3,109,799)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): WIP	124,382	124,382	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 347,790	\$ 1,838,301	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,306,891	\$ 2,975,247	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 325,677	\$ 325,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,715	31,715	28
29	Short-Term Notes Payable	4,247,024	4,247,024	29
30	Accrued Salaries Payable	226,880	226,880	30
	Accrued Taxes Payable (excluding real estate taxes)	217,276	217,276	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,970	32
33	Accrued Interest Payable		5,243	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to/from Related Party	21,806	21,806	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,070,378	\$ 5,107,591	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,394,470	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)	\$	\$ 2,394,470	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,070,378	\$ 7,502,061	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,763,487)	\$ (4,526,814)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,306,891	\$ 2,975,247	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,070,100)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,070,100)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(577,010)	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) PY Adjustments	(116,377)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (693,387)	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)	\$ (3,763,487)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,197,143	1
2	Discounts and Allowances for all Levels	(1,059,264)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,137,879	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,821,689	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,821,689	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	1,631	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,554	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,287	19
20	Radiology and X-Ray	5,151	20
21	Other Medical Services	15,343	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 331,966	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(154)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (154)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(21,960)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (21,960)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,269,420	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,237,051	31
32	Health Care	2,922,777	32
33	General Administration	2,388,002	33
B. Capital Expense			
34	Ownership	336,742	34
C. Ancillary Expense			
35	Special Cost Centers	961,858	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,846,430	40
41	Income before Income Taxes (line 30 minus line 40)**	(577,010)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (577,010)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,280,758.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,009,258.00	45
46	MMAI-Medicaid is the Primary Payer	1,233,035.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	773,804.00	48
49	Medicare Part A	641,443.00	49
50	Other-(specify) Managed Care	199,581.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,137,879	56

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,539	3,749	\$ 189,180	\$ 50.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,983	7,507	406,855	54.20	3
4	Licensed Practical Nurses	15,078	16,273	451,068	27.72	4
5	CNAs & Orderlies	49,660	52,830	1,065,080	20.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,467	1,592	27,710	17.41	9
10	Activity Assistants	2,426	2,669	53,488	20.04	10
11	Social Service Workers	1,675	1,780	48,365	27.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,901	14,797	255,276	17.25	15
16	Dishwashers					16
17	Maintenance Workers	2,922	3,105	60,467	19.47	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,988	2,258	111,328	49.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,402	5,730	160,135	27.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,616	1,773	27,318	15.41	31
32	Other Health Care(specify)					32
33	Other(specify)	1,888	2,080	74,211	35.68	33
34	TOTAL (lines 1 - 33)	108,545	116,143	\$ 2,930,481 *	\$ 25.23	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	1,853	\$ 19,213	V01-3	35
36	Medical Director	Monthly	28,079	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,500	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	46	3,200	V11-3	44
45	Social Service Consultant	46	3,200	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,945	\$ 60,192		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,958	\$ 160,665	V10-3	50
51	Licensed Practical Nurses	2,844	163,663	V10-3	51
52	Certified Nurse Assistants/Aides	1,990	77,003	V10-3	52
53	TOTAL (lines 50 - 52)	6,792	\$ 401,331		53

XIX. SUPPORT SCHEDULES				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
A. Administrative Salaries		Ownership		Description		Description	
Name	Function	%	Amount		Amount		Amount
Candy Tucker	Administrator	0	\$ 43,510	Workers' Compensation Insurance	\$ 53,772	IDPH License Fee	\$
Lee Ann Smith	Administrator	0	56,156	Unemployment Compensation Insurance		Advertising: Employee Recruitment	6,417
Jeffrey White	Administrator	0	11,662	FICA Taxes	237,672	Health Care Worker Background Check	2,307
				Employee Health Insurance	82,765	(Indicate # of checks performed 126)	
				Employee Meals		Patient Background Checks	106
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues (total from pg 22, #4)	11,011
				Other benefits	(8,324)	Other Licenses	3,444
						Other Dues	1,941

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- 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
- (10) 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.
- (11) 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. \$ _____
- (12) 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
- (13) Has an audit been performed by an independent certified public accounting firm
Firm Name: N/A No
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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: