

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

<p>I. IDPH License ID Number: <u>0051870</u></p> <p>Facility Name: <u>Dixon Rehabilitation & Health Care Center</u></p> <p>Address: <u>800 Division Street</u> <u>Dixon</u> <u>61021</u> Number City Zip Code</p> <p>County: <u>Lee</u></p> <p>Telephone Number: <u>(815) 284-3393</u> Fax # <u>(815) 284-2066</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/1/2008</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4446</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>600 Washington Ave Suite 1800, St. Louis, MO 63101</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(314) 925-4446</u> Fax # <u>(314) 925-4350</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u>		(Firm Name & Address) <u>600 Washington Ave Suite 1800, St. Louis, MO 63101</u>		(Telephone) <u>(314) 925-4446</u> Fax # <u>(314) 925-4350</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
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Facility Name & ID Number Dixon Rehabilitation & Health Care Center

0051870 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	97	Skilled (SNF)	97	35,405	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	97	TOTALS	97	35,405	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,406	10,519	5,977	27,902	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,406	10,519	5,977	27,902	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.81%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 5/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 97 and days of care provided 3,894

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Dixon Rehabilitation & Health Care Center # 0051870 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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		16,069	461,895	477,964		477,964		477,964		1
2	Food Purchase		13,379		13,379		13,379	(1,601)	11,778		2
3	Housekeeping		13,594	92,443	106,037		106,037		106,037		3
4	Laundry		7,139	61,563	68,702		68,702		68,702		4
5	Heat and Other Utilities			116,279	116,279		116,279		116,279		5
6	Maintenance	89,049	12,150	60,020	161,219		161,219		161,219		6
7	Other (specify):*										7
8	TOTAL General Services	89,049	62,331	792,200	943,580		943,580	(1,601)	941,979		8
	B. Health Care and Programs										
9	Medical Director					18,000	18,000		18,000		9
10	Nursing and Medical Records	1,952,729	109,304	28,890	2,090,923	(18,000)	2,072,923		2,072,923		10
10a	Therapy										10a
11	Activities	44,862	6,361	43,716	94,939		94,939		94,939		11
12	Social Services	34,617		3,055	37,672		37,672		37,672		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,032,208	115,665	75,661	2,223,534		2,223,534		2,223,534		16
	C. General Administration										
17	Administrative	120,026			120,026		120,026		120,026		17
18	Directors Fees										18
19	Professional Services			117,000	117,000		117,000	302,443	419,443		19
20	Dues, Fees, Subscriptions & Promotions			14,300	14,300		14,300	(3,479)	10,821		20
21	Clerical & General Office Expenses	118,846	22,956	528,160	669,962		669,962	(528,853)	141,109		21
22	Employee Benefits & Payroll Taxes			323,747	323,747		323,747		323,747		22
23	Inservice Training & Education			765	765		765		765		23
24	Travel and Seminar			6,158	6,158		6,158		6,158		24
25	Other Admin. Staff Transportation			4,673	4,673		4,673	(800)	3,873		25
26	Insurance-Prop.Liab.Malpractice			127,451	127,451		127,451		127,451		26
27	Other (specify):*										27
28	TOTAL General Administration	238,872	22,956	1,122,254	1,384,082		1,384,082	(230,689)	1,153,393		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,360,129	200,952	1,990,115	4,551,196		4,551,196	(232,290)	4,318,906		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 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	
	D. Ownership											
30	Depreciation			44,969	44,969		44,969	19,840	64,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,984	27,984		27,984	157,805	185,789			32
33	Real Estate Taxes			48,547	48,547		48,547		48,547			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			5,151	5,151		5,151		5,151			35
36	Other (specify):*											36
37	TOTAL Ownership			426,651	426,651		426,651	(122,355)	304,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,330	651,919	834,249		834,249		834,249			39
40	Barber and Beauty Shops		56		56		56		56			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,382	198,382		198,382		198,382			42
43	Other (specify):* Marketing	46,954		40,204	87,158		87,158	(87,158)				43
44	TOTAL Special Cost Centers	46,954	182,386	890,505	1,119,845		1,119,845	(87,158)	1,032,687			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,407,083	383,338	3,307,271	6,097,692		6,097,692	(441,803)	5,655,889			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	(1,069)	02		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	(8,345)	30		9
10	Interest and Other Investment Income	(9,842)	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	(12,583)	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	(147,545)	21		24
25	Fund Raising, Advertising and Promotional	(40,204)	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	(51,916)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (271,504)		\$	30

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)	(170,299)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (170,299)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (441,803)		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

BHF USE ONLY							
48		49		50		51	52

Dixon Rehabilitation & Health Care Center

ID# 0051870

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Dues	\$ (1,785)	20	1
2	PAC Dues	(427)	20	2
3	Rotary Internation Dues	(1,267)	20	3
4	Misc Income	(151)	21	4
5	Vending Machine	(532)	02	5
6	Marketing Salaries	(46,954)	43	6
7	Marketing Mileage	(800)	25	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(51,916)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dixon Rehabilitation & Health Care Center# 0051870

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,601)	0	0	0	0	0	0	0	0	0	0	(1,601)	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	(1,601)	0	0	0	0	0	0	0	0	0	0	(1,601)	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	477	301,966	0	0	0	0	0	0	0	0	302,443	19
20	Fees, Subscriptions & Promotions	(3,479)	0	0	0	0	0	0	0	0	0	0	(3,479)	20
21	Clerical & General Office Expenses	(160,279)	0	(368,574)	0	0	0	0	0	0	0	0	(528,853)	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	(800)	0	0	0	0	0	0	0	0	0	0	(800)	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	(164,558)	477	(66,608)	0	(230,689)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(166,159)	477	(66,608)	0	(232,290)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dixon Rehabilitation & Health Care Center # 0051870 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,345)	21,246	6,939	0	0	0	0	0	0	0	0	19,840	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,842)	195,631	(27,984)	0	0	0	0	0	0	0	0	157,805	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(18,187)	(83,123)	(21,045)	0	(122,355)	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):*	(87,158)	0	0	0	0	0	0	0	0	0	0	(87,158)	43
44	TOTAL Special Cost Centers	(87,158)	0	0	0	0	0	0	0	0	0	0	(87,158)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(271,504)	(82,646)	(87,653)	0	(441,803)	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: 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		
1	V	34 Rent	\$ 300,000	Ti-Dixon Illinois, LLC	100.00%	\$	(300,000)	1
2	V	32 Interest		Ti-Dixon Illinois, LLC	100.00%	195,631	195,631	2
3	V	19 Legal Fees		Ti-Dixon Illinois, LLC	100.00%	477	477	3
4	V	30 Depreciation		Ti-Dixon Illinois, LLC	100.00%	21,246	21,246	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 300,000			\$ 217,354	\$ * (82,646)	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	21 Management Fees	\$ 362,511	Tutera Health Care Services	100.00%	\$	\$ (362,511)
16	V	19 Management - Operating	63,439	Tutera Health Care Services	100.00%	365,405	301,966
17	V	30 Managemet - Depreciation		Tutera Health Care Services	100.00%	6,939	6,939
18	V	21 Furniture Purchases	258	Bethany Health Care & Rehab		258	
19	V	21 Asset Managemet Fees	6,063	JCT Capital, Inc			(6,063)
20	V	26 Insurance	113,553	LTC Plus Insurance, Inc		113,553	
21	V	22 Insurance	3,451	CarePlus Insurance		3,451	
22	V	19 Data Processing & Legal	243	Walnut Creek Management		243	
23	V	20 Employment Ads & Licenses	2,370	Walnut Creek Management		2,370	
24	V	21 Postage/Small Equip/Entertainment	8,277	Walnut Creek Management		8,277	
25	V	22 Employment Expense	200	Walnut Creek Management		200	
26	V	24 Seminar	4,122	Walnut Creek Management		4,122	
27	V	10 Nursing Supplies	127	Walnut Creek Management		127	
28	V	32 Interest	27,984	JCT Capital, Inc			(27,984)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 592,598			\$ 504,945	\$ * (87,653)

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

Facility Name & ID Number

Dixon Rehabilitation & Health Care Center

0051870

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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, LLC	100%	Auburn Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2			Windsor Rehab & Health Care Center	Terrell, TX	Carnegie Village Senio	Belton, MO	IL/AL	2
3			Bethany Rehab & Health Care Center	DeKalb, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Carlinville Rehab & Health Care Center	Carlinville, IL	Country Gardens Assi	Muskogee, OK	AL	4
5			Coulterville Rehab & Health Care Center	Coulterville, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Cent	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	Boiling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Assisted	Laurinburn, NC	AL	11
12			Mattoon Rehab & Health Care Center	Mattoon, IL	Bright Oaks of Aurora	Aurora, IL	AL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Paradise Park Assisted	Fox Lake, IL	AL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL	TI- Dixon	Dixon, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LLC	Kansas City, MO	Building Company	15
16			Montgomery Children's Speicalty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Management Comp	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 Cente	Raytown, MO	Walnut Creek Manger	Kansas City, MO	Management Comp	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New En	Kansas City, MO	Management Comp	19
20			Holly Hill Rehab & Health Care Center	Sulphur, LA	Tutera Investments, In	Kansas City, MO	Management Comp	20
21			Rosewood Rehab & Health Care Center	Lake Charles, LA	JCT Capital Inc	Kansas City, MO	Management Comp	21
22			St. Paul's Senior Community	Belleville, IL	Tutera Group Inc	Kansas City, MO	Management Comp	22
23			Greenfield Manor	Greenfield, I	LTC Plus Insurance Ir	Kansas City, MO	Insurance Company	23
24			Griswold Care Center	Grsiswold, IA	Residence at Pleasont	Pleasantan	AI/IL	24
25			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Mt Ayr	Mt.Ayr, IA	AL/IL	25
26			Stratford Rehab & Health Care Center	Overland Park, KS	Missiona Chateua Sen	Prairie Village, KS	AL/IL	26
27			Carnegie Village Rehab & Health Care Center	Belton, MO				27
28			Tiffany Springs Rehab & Health Care Center	Kansas City, MO				28
29			Northland Rehab & Health Care Center	Kansas City, MO				29
30			Westview of Derby	Derby, KS				30

Facility Name & ID Number Dixon Rehabilitation & Health Care Center # 0051870 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Dixon Rehabilitation & Health Care Center # 0051870 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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	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	19	Management Fee - Operating	Direct Cost	193,500,518	48	\$ 12,214,787	\$ 8,837,460	5,788,592	\$ 365,407	1
2	30	Management Fee - Depreciation	Direct Cost	193,500,518	48	231,947		5,788,592	6,939	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					\$ 12,446,734	\$ 8,837,460		\$ 372,346	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Tutera Group Inc	X		Note Payable (TI Dixon)			\$	\$ 3,323,790		0.0700	\$ 195,631	1								
2	JCT Capital	X		Note Payable				3,187,657		0.0100	27,984	2								
3	Interest Income Offset										(9,842)	3								
4	Related Party Offset										(27,984)	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$ 6,511,447			\$ 185,789	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$	\$ 6,511,447			\$ 185,789	15								

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	47,832	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.)		\$	49,058	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,226	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,321	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.		\$	48,547	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	45,538	8	
	2014	45,088	9	
	2015	45,924	10	
	2016	47,832	11	
	2017	49,058	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dixon Rehabilitation & Health Care Center COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051870

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

TELEPHONE (314) 925-4446 FAX #: (314) 925-4350

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>07-08-04-376-011</u>	<u>Long-Term Care</u>	\$ <u>49,058.32</u>	\$ <u>49,058.32</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>49,058.32</u></u>	\$ <u><u>49,058.32</u></u>

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 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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

Facility Name & ID Number Dixon Rehabilitation & Health Care Center

0051870 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,700 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Long-Term Care, 28,700, 2002, \$92,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 28,700, (blank), \$92,000, 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	97		2002	1973	\$ 822,167	\$ 25,821	27	\$ 25,821	\$	\$ 653,568
5										
6										
7										
8										
	Improvement Type**									
9		Door Alarm System		2014	15,105	757	10	757		10,815
10		Generator Replacement		2014	30,599	3,525	5	3,525		25,311
11		Courtyard Sidewalk & Patio		2015	11,544	770	15	770		1,924
12		Flat Roof		2015	34,694	1,735	20	1,735		4,192
13		100 Hall shower torn down to studs, expanded, plumbing replaced, tile re		2016	15,259	1,534	7	1,534		2,382
14		dry wall replaced and paint								
15		LED Lights-Bldgg Perimeter		2017	9,918	496	10	496		496
16		Hand Rails Hallways 100, 200 & 300		2018	22,300	619	15	619		619
17		Lighting - 100, 200 & 300 Hallways		2018	5,898	164	15	164		164
18		Canopy renovation & Window Repair		2018	7,225	201	15	201		201
19		Painting - 100, 200 & 300 Hallways; Room 302 and 305; Entry way;								
20		conference room; dinning room and nurse station		2018	56,933	1,581	15	1,581		1,581
21		Carpet & Vinyl Flooring & cover base - 100, 200 & 300 Hallways, Room 302								
22		Room 305, conference room, dinning room and nurse station		2018	56,596	1,572	15	1,572		1,572
23		Renovation - Expand Entryway: Construction, drywall, paint, flooring		2018	27,256	758	15	758		758
24										
25		Home Office Allocation				6,939		6,939		
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	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)	\$	\$		\$	\$	\$	70
			1,115,494		46,472		46,472	703,583

**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	\$ 77,529	\$ 4,540	\$ 4,540	\$	Various	\$ 32,011	71
72	Current Year Purchases	120,438	7,366	7,366		Various	7,366	72
73	Fully Depreciated Assets	87,635				Various	87,635	73
74								74
75	TOTALS	\$ 285,602	\$ 11,906	\$ 11,906	\$		\$ 127,012	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		Ford Van	2012	\$ 13,000	\$	\$	\$	4	\$ 13,000	76
77		Ford Transit 350 XL Van	2018	55,185	6,431	6,431		5	6,431	77
78										78
79										79
80	TOTALS			\$ 68,185	\$ 6,431	\$ 6,431	\$		\$ 19,431	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,561,281	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,809	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,809	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)	\$ 850,026	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		\$	92
93			93
94			94
95		\$	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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,151 Description: Dishwasher, Coper (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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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)	\$			

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	

- (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.

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	Licensed Occupational Therapist	V39-3	hrs	\$	3,777	\$ 260,538	\$	3,777	\$ 260,538	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		1,349	101,138		1,349	101,138	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		3,878	265,488	1,024	3,878	266,512	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				110,983		110,983	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See WTB</u>					24,755	70,323		95,078	13
14	TOTAL			\$	9,004	\$ 651,919	\$ 182,330	9,004	\$ 834,249	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.

Facility Name & ID Number **Dixon Rehabilitation & Health Care Center**

0051870

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 287,118	\$ 291,168	1
2	Cash-Patient Deposits	34,773	34,773	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	603,055	603,055	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,581	131,581	6
7	Other Prepaid Expenses	383,136	383,136	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	6,639	6,639	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,446,302	\$ 1,450,352	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		92,000	13
14	Buildings, at Historical Cost		822,167	14
15	Leasehold Improvements, at Historical Cost	317,997	317,997	15
16	Equipment, at Historical Cost	254,482	329,117	16
17	Accumulated Depreciation (book methods)	(121,823)	(850,026)	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 (specify):			22
23	Other(specify): Other Long-Term Assets	14,362	(8,878)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 465,018	\$ 702,377	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,911,320	\$ 2,152,729	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 524,243	\$ 524,243	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,773	34,773	28
29	Short-Term Notes Payable	3,187,657	3,187,657	29
30	Accrued Salaries Payable	195,632	195,632	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,822	32,822	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,321	47,321	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,022,448	\$ 4,022,448	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		3,323,790	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,323,790	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,022,448	\$ 7,346,238	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,111,128)	\$ (5,193,509)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,911,320	\$ 2,152,729	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,066,447)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,066,447)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(44,681)	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)	\$ (44,681)	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)	\$ (2,111,128)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Dixon Rehabilitation & Health Care Center

0051870

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	\$ 5,236,786	1
2	Discounts and Allowances for all Levels	(3,316,671)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,920,115	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,754,560	6
7	Oxygen	46,559	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,801,119	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	226,025	17
18	Sale of Supplies to Non-Patients	21,951	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	73,276	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 321,252	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,842	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,842	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Machine Revenue</u>	532	28
28a	<u>Miscellaneous Revenue</u>	151	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 683	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,053,011	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	943,580	31
32	Health Care	2,223,534	32
33	General Administration	1,384,082	33
B. Capital Expense			
34	Ownership	426,651	34
C. Ancillary Expense			
35	Special Cost Centers	921,463	35
36	Provider Participation Fee	198,382	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,097,692	40
41	Income before Income Taxes (line 30 minus line 40)**	(44,681)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (44,681)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,641,780	44
45	Private Pay - Net Inpatient Revenue	1,852,834	45
46	Medicare - Net Inpatient Revenue	(1,287,888)	46
47	Other-(specify) <u>Managed Care</u>	(286,611)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,920,115	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.

Facility Name & ID Number Dixon Rehabilitation & Health Care Center

0051870

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	1,929	2,083	\$ 84,036	\$ 40.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,193	14,782	472,470	31.96	3
4	Licensed Practical Nurses	19,413	20,359	606,075	29.77	4
5	CNAs & Orderlies	57,088	59,537	771,522	12.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	659	667	12,499	18.74	9
10	Activity Assistants	2,654	2,731	32,363	11.85	10
11	Social Service Workers	1,989	2,069	34,617	16.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,981	4,237	89,049	21.02	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,920	2,080	120,026	57.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,822	7,320	118,846	16.24	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	986	1,190	18,626	15.65	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	2,024	2,064	46,954	22.75	33
34	TOTAL (lines 1 - 33)	113,658	119,119	\$ 2,407,083 *	\$ 20.21	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	\$ 461,895	V01-3	35
36	Medical Director	Monthly	18,000	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,587	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	41,136	V11-3	44
45	Social Service Consultant	Monthly	3,055	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 532,673		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	42	1,971	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	42	\$ 1,971		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Katheryn May</u>	<u>Administrator</u>	<u>0</u>	\$ <u>120,026</u>	<u>Workers' Compensation Insurance</u>	\$ <u>55,693</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>	<u>2,293</u>	
				<u>FICA Taxes</u>	<u>193,282</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>64,916</u>	<u>(Indicate # of checks performed <u>98</u>)</u>	<u>983</u>	
				<u>Employee Meals</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>IL Health Care Associaiton</u>	<u>5,941</u>	
				<u>Other Benefits</u>	<u>9,856</u>	<u>IL Secretary of State</u>	<u>75</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>120,026</u>			<u>Other Licenses</u>	<u>2,472</u>	
(List each licensed administrator separately.)						<u>Other Dues and Subscriptions</u>	<u>2,536</u>	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>323,747</u>	
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
<u>N/A</u>			\$ _____	Description	Line #	Amount	Description	Amount
				<u>N/A</u>			<u>Out-of-State Travel</u>	\$ <u>2,297</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____				<u>In-State Travel</u>	<u>1,541</u>
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			\$ _____	
Vendor/Payee	Type	Amount					<u>Seminar Expense</u>	<u>2,320</u>
<u>Daniel Maher Law Offices</u>	<u>Legal</u>	<u>1,460</u>						
<u>Heyl Royster Voelker & Allen</u>	<u>Legal</u>	<u>1,538</u>					<u>Entertainment Expense</u>	(_____)
<u>Other Accurals</u>	<u>Legal</u>	<u>5,000</u>					TOTAL (agree to Sch. V, line 24, col. 8)	
<u>CliftonLarsonAllen LLP</u>	<u>Accounting/Cost Report</u>	<u>10,100</u>					\$ <u>6,158</u>	
<u>PointClickCare Technologies</u>	<u>Data Processing</u>	<u>26,773</u>						
<u>Walnut Creek Management Co LLC</u>	<u>Data Processing</u>	<u>68,211</u>						
<u>Allscripts Healthcare LLC</u>	<u>Data Processing</u>	<u>2,280</u>						
<u>Pinnacle Quality Insight</u>	<u>Professional Services</u>	<u>1,538</u>						
<u>Property Valuation Services</u>	<u>Professional Services</u>	<u>100</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>117,000</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Dixon Rehabilitation & Health Care Center

0051870

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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, \$5,941
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,568 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. \$ 198,382
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? N/A 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 benefit 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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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 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