



Facility Name & ID Number Mattoon Rehabilitation & Health Care Center

# 0051896 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	148	Skilled (SNF)	148	54,020	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	148	TOTALS	148	54,020	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	15,014	6,860	11,504	33,378	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,014	6,860	11,504	33,378	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.79%

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 148 and days of care provided 6,141

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 Mattoon Rehabilitation & Health Care Center # 0051896 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
	<b>A. General Services</b>										
1	Dietary		7,068	460,648	467,716		467,716		467,716		1
2	Food Purchase		11,112		11,112		11,112	(1,544)	9,568		2
3	Housekeeping		18,747	136,603	155,350		155,350		155,350		3
4	Laundry		16,012	96,063	112,075		112,075	2,118	114,193		4
5	Heat and Other Utilities			201,379	201,379		201,379		201,379		5
6	Maintenance	56,487	16,773	91,016	164,276		164,276	6,878	171,154		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	56,487	69,712	985,709	1,111,908		1,111,908	7,452	1,119,360		8
	<b>B. Health Care and Programs</b>										
9	Medical Director					19,500	19,500		19,500		9
10	Nursing and Medical Records	2,253,572	112,517	82,139	2,448,228	(19,500)	2,428,728	7,818	2,436,546		10
10a	Therapy										10a
11	Activities	30,030	9,711	56,397	96,138		96,138		96,138		11
12	Social Services	57,126		3,458	60,584		60,584		60,584		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,340,728	122,228	141,994	2,604,950		2,604,950	7,818	2,612,768		16
	<b>C. General Administration</b>										
17	Administrative	97,987			97,987		97,987		97,987		17
18	Directors Fees										18
19	Professional Services			187,753	187,753		187,753	386,319	574,072		19
20	Dues, Fees, Subscriptions & Promotions			20,801	20,801		20,801	(5,065)	15,736		20
21	Clerical & General Office Expenses	198,057	18,404	639,161	855,622		855,622	(568,826)	286,796		21
22	Employee Benefits & Payroll Taxes			397,949	397,949		397,949		397,949		22
23	Inservice Training & Education			654	654		654		654		23
24	Travel and Seminar			1,884	1,884		1,884		1,884		24
25	Other Admin. Staff Transportation			10,218	10,218		10,218	(6,472)	3,746		25
26	Insurance-Prop.Liab.Malpractice			332,381	332,381		332,381	626	333,007		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	296,044	18,404	1,590,801	1,905,249		1,905,249	(193,418)	1,711,831		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,693,259	210,344	2,718,504	5,622,107		5,622,107	(178,148)	5,443,959		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	
	<b>D. Ownership</b>											
30	Depreciation			2,460	2,460		2,460	186,974	189,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,021	1,021		1,021	92,613	93,634			32
33	Real Estate Taxes			87,620	87,620		87,620	(25,174)	62,446			33
34	Rent-Facility & Grounds			290,337	290,337		290,337	(290,337)				34
35	Rent-Equipment & Vehicles			10,743	10,743		10,743		10,743			35
36	Other (specify):* <b>Mortgage Ins</b>							21,848	21,848			36
37	<b>TOTAL Ownership</b>			392,181	392,181		392,181	(14,076)	378,105			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,174	1,042,359	1,310,533		1,310,533		1,310,533			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,236	246,236		246,236		246,236			42
43	Other (specify):* <b>Marketing</b>	84,853		29,676	114,529		114,529	(114,529)				43
44	<b>TOTAL Special Cost Centers</b>	84,853	268,174	1,318,271	1,671,298		1,671,298	(114,529)	1,556,769			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,778,112	478,518	4,428,956	7,685,586		7,685,586	(306,753)	7,378,833			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	(1,544)	2		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	859	30		9
10	Interest and Other Investment Income	(10,134)	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	(28,721)	21		18
19	Entertainment	(11,579)	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	(24,870)	21		24
25	Fund Raising, Advertising and Promotional	(29,676)	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	(99,396)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (205,061)		\$	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)	(101,692)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (101,692)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (306,753)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

**Mattoon Rehabilitation & Health Care Center**

ID# 0051896

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (84,853)	43	1
2	PAC Dues	(710)	20	2
3	Rotary Dues	(60)	20	3
4	Misc Income	(3,006)	21	4
5	Lobbying Portion of Dues	(2,935)	20	5
6	Chamber of Commerce Dues	(1,360)	20	6
7	Marketing Mileage	(6,472)	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	<b>Total</b>	(99,396)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mattoon Rehabilitation & Health Care Center# 0051896

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,544)	0	0	0	0	0	0	0	0	0	0	(1,544)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	2,118	0	0	0	0	0	0	0	0	0	2,118	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	6,878	0	0	0	0	0	0	0	0	0	6,878	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,544)</b>	<b>8,996</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,452</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,818	0	0	0	0	0	0	0	0	0	7,818	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>7,818</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,818</b>	<b>16</b>
	<b>C. General Administration</b>													
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	11,136	375,183	0	0	0	0	0	0	0	0	386,319	19
20	Fees, Subscriptions & Promotions	(5,065)	0	0	0	0	0	0	0	0	0	0	(5,065)	20
21	Clerical & General Office Expenses	(68,176)	2,212	(502,862)	0	0	0	0	0	0	0	0	(568,826)	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	(6,472)	0	0	0	0	0	0	0	0	0	0	(6,472)	25
26	Insurance-Prop.Liab.Malpractice	0	626	0	0	0	0	0	0	0	0	0	626	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(79,713)</b>	<b>13,974</b>	<b>(127,679)</b>	<b>0</b>	<b>(193,418)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(81,257)</b>	<b>30,788</b>	<b>(127,679)</b>	<b>0</b>	<b>(178,148)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mattoon Rehabilitation & Health Care Center # 0051896 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	859	177,432	8,683	0	0	0	0	0	0	0	0	186,974	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,134)	103,768	(1,021)	0	0	0	0	0	0	0	0	92,613	32
33	Real Estate Taxes	0	(25,174)	0	0	0	0	0	0	0	0	0	(25,174)	33
34	Rent-Facility & Grounds	0	(290,337)	0	0	0	0	0	0	0	0	0	(290,337)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	21,848	0	0	0	0	0	0	0	0	0	21,848	36
37	<b>TOTAL Ownership</b>	<b>(9,275)</b>	<b>(12,463)</b>	<b>7,662</b>	<b>0</b>	<b>(14,076)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(114,529)	0	0	0	0	0	0	0	0	0	0	(114,529)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(114,529)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(114,529)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(205,061)</b>	<b>18,325</b>	<b>(120,017)</b>	<b>0</b>	<b>(306,753)</b>	<b>45</b>							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 290,337	TI - Mattoon	100.00%	\$	(290,337)	1
2	V	32 Interest		TI - Mattoon	100.00%	103,057	103,057	2
3	V	19 Legal/Accounting		TI - Mattoon	100.00%	11,136	11,136	3
4	V	36 Mortgage Insurance		TI - Mattoon	100.00%	21,848	21,848	4
5	V	30 Depreciation		TI - Mattoon	100.00%	177,432	177,432	5
6	V	32 Amortization of Financing Costs		TI - Mattoon	100.00%	711	711	6
7	V	6 Maintenance		TI - Mattoon	100.00%	6,878	6,878	7
8	V	33 Real Estate Taxes	87,620	TI - Mattoon	100.00%	62,446	(25,174)	8
9	V	26 Insurance	14,403	TI - Mattoon	100.00%	15,029	626	9
10	V	21 Small Equip/Supplies/Furniture		TI - Mattoon	100.00%	2,212	2,212	10
11	V	4 Linens		TI - Mattoon	100.00%	2,118	2,118	11
12	V	10 Nursing Small Equip		TI - Mattoon	100.00%	7,818	7,818	12
13	V							13
14	Total		\$ 392,360			\$ 410,685	\$ * 18,325	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 <u>Insurnace</u>	\$ 6,768	<u>CarePlus Insurance, Inc</u>		\$ 6,768	\$
16	V	21 <u>Management Fee</u>	475,112	<u>Tutera Health Care Services</u>	100.00%		(475,112)
17	V	19 <u>Management - Operating</u>	82,065	<u>Tutera Health Care Services</u>	100.00%	457,248	375,183
18	V	30 <u>Management - Depreciation</u>		<u>Tutera Health Care Services</u>	100.00%	8,683	8,683
19	V	25 <u>Mileage Reimbursement</u>	171	<u>Carlinville Rehab &amp; Healthcare</u>		171	
20	V	6 <u>Maintenance</u>	406	<u>Carlinville Rehab &amp; Healthcare</u>		406	
21	V	25 <u>Mileage Reimbursement</u>	71	<u>Hillsboro TI</u>		71	
22	V	10 <u>Nursing Agency LPN</u>	350	<u>Hillsboro TI</u>		350	
23	V	6 <u>Maintenance</u>	171	<u>Hillsboro TI</u>		171	
24	V	21 <u>Asset Management Fees</u>	27,750	<u>JCT Capital LLC</u>			(27,750)
25	V	10 <u>Nursing Aides Agency</u>	51	<u>Moweaqua Rehabilitation &amp; Health</u>		51	
26	V	6 <u>Maintenance</u>	485	<u>Moweaqua Rehabilitation &amp; Health</u>		485	
27	V	6 <u>Maintenance Repairs</u>	307	<u>Walnut Creek Management</u>		307	
28	V	10 <u>Nursing Supplies</u>	127	<u>Walnut Creek Management</u>		127	
29	V	19 <u>Legal &amp; Accounting Fees</u>	325	<u>Walnut Creek Management</u>		325	
30	V	20 <u>Employee Want Ads</u>	917	<u>Walnut Creek Management</u>		917	
31	V	21 <u>Small Equip/Postage/Telephone</u>	2,269	<u>Walnut Creek Management</u>		2,269	
32	V	22 <u>Employment Expense</u>	2,700	<u>Walnut Creek Management</u>		2,700	
33	V	26 <u>Insurnace</u>	316,438	<u>LTC Plus Insurance, Inc.</u>		316,438	
34	V	32 <u>Interest</u>	1,021	<u>JCT Capital LLC</u>			(1,021)
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 917,504			\$ 797,487	\$ * (120,017)

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

Facility Name &amp; ID Number

Mattoon Rehabilitation &amp; Health Care Center

# 0051896

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	99%	Auburn Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT FLP, LLC	1%	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			Dixon Rehab & Health Care Center	Dixon, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Hamilton Memorial Rehab & Health Care Cente	McLeansboro, IL	Victory Hills Senior Li	Kansas City MO	IL/AL	9
10			Highland Rehab & Health Care Center	Kansas City, MO	Wesley Court Assisted	Boiling Springs, SC	AL	10
11			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Willow Place Assisted	Laurinburg, NC	AL	11
12			Lakeland Rehab & Health Care Center	Effingham, 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 Mattoon	Mattoon, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City MO	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 Manage	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 LLC	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, IA	LTC Plus Insurance Ir	Kansas City MO	Insurance Company	23
24			Griswold Care Center	Griswold, 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 Mattoon Rehabilitation & Health Care Cente # 0051896 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 Mattoon Rehabilitation & Health Care Center

# 0051896

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, MO 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	7,243,490	\$ 457,248	1
2	30	Management Fee - Depreciation	Direct Cost	193,500,518	48	231,947		7,243,490	8,683	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		\$ 465,931	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD		X	Mortgage			\$	\$ 3,310,606		\$ 103,647	1									
2	HUD Financing Cost		X							711	2									
3	Interest Income Offset									(590)	3									
4											4									
5											5									
<b>Working Capital</b>																				
6	JCT Capital	X		Note Payable			1,110,000	357,181		0.0100	1,021	6								
7	Interest Income Offset									(10,134)	7									
8	Related Party Offset									(1,021)	8									
9	<b>TOTAL Facility Related</b>						\$ 1,110,000	\$ 3,667,787		\$ 93,634	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$	14									
15	<b>TOTALS (line 9+line14)</b>						\$ 1,110,000	\$ 3,667,787		\$ 93,634	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,848 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 2017 report.		\$	<b>111,076</b>	<b>1</b>
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.)		\$	<b>85,902</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(25,174)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>87,620</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>62,446</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	<b>62,946</b>	<b>8</b>	
	2014	<b>63,727</b>	<b>9</b>	
	2015	<b>65,338</b>	<b>10</b>	
	2016	<b>111,076</b>	<b>11</b>	
	2017	<b>85,902</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2017	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Mattoon Rehabilitation & Health Care Center COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0051896

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>07-1-00922-000</u>	<u>Long-Term Care</u>	\$ <u>85,902.06</u>	\$ <u>85,902.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>85,902.06</u></u>	\$ <u><u>85,902.06</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   X   NO

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

**C. Tax Bills**

Attach 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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,929 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Long-Term Care</u>	<u>38,929</u>	<u>2012</u>	<u>\$ 167,255</u>	1
2					2
3	TOTALS	<u>38,929</u>		<u>\$ 167,255</u>	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	148		2012	1977	\$ 2,873,745	\$ 104,500	27	\$ 104,500	\$	\$ 727,156	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		2012 IMPROVEMENTS	2012		14,318	628	Various	628		11,147	9
10		7.5 TON ROOF TOP UNIT	2015		8,973	1,282	7	1,282		4,380	10
11											11
12		Home Office Depreciation				8,683		8,683			12
13											13
14		ASPHALT REPAVING (TI MATTOON)	2013		24,652	799	15	799		17,465	14
15		DOOR LEVERS (I38) (TI MATTOON)	2013		12,400	576	7	576		11,536	15
16		ROOF (TI MATTOON)	2013		68,723	2,499	27	2,499		12,807	16
17		10 TON HVAC (TI MATTOON)	2013		11,186	499	7	499		9,938	17
18		VINYL FLOOR/PAINT IN 300 HALL/ROTUNDA/ENTRY (TI MATTOON)	2015		21,936	1,370	7	1,370		18,510	18
19		EXTERIOR PAINTING (TI MATTOON)	2015		22,980	2,010	7	2,010		17,956	19
20		2016/2017 RENOVATION (TI MATTOON) - Architects									20
21		Building Redesign Plans	2017		21,083	781	27	781		1,302	21
22		2016/2017 RENOVATION (TI MATTOON) - Electrical - new wiring and	2017		44,553	1,650	27	1,650		2,750	22
23		fixtures - Lotus Wing Corridor; 24 Patient Rooms & bathrooms;									23
24		shower room, medical records, living & dining room and nurses station									24
25		2016/2017 RENOVATION (TI MATTOON) - Lotus Corridor	2017		39,600	1,467	27	1,467		2,445	25
26		Remove & replace LVT flooring; remove & replace handrails; doorframe;									26
27		repair/replace; paint doors & door frames; instal new signage									27
28		Replace kickplates and paint walls and cerilings									28
29		2016/2017 RENOVATION (TI MATTOON) - Lotus Patient Rooms (24 to	2017		92,352	3,420	27	3,420		5,700	29
30		Install new LVT Flooring, Install new closet doors, repair/refinish doors;									30
31		install new door hardware; install new windowsills, fix drywall, repair									31
32		door trim/casing and paint ceiling and walls.									32
33		2016/2017 RENOVATION (TI MATTOON) - Lotus Bathrooms	2017		78,273	2,899	27	2,899		4,832	33
34		Install new ceramic tile on floor and walls; drywall repair; paint on									34
35		ceiling, walls, door and doorframe. Install new toilets, sinks, faucets,									35
36											36

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

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

See Page 12A, Line 70 for total

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

1	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	2016/2017 RENOVATION (TI MATTOON) - Shower Room & Medical R	2017	\$ 24,486	\$ 907	27	\$ 907	\$	\$ 1,512	37
38	Demolition of tub pedistal., and concrete for new shower								38
39	Remove old flooring & install new ceramic tile in in shower								39
40	room and LVT in medical recordss.								40
41	Install new ceramic tile on walls, drywall and paint on walls &								41
42	ceiling of shower room. Relocate door/door frame								42
43	paint door/doorframe.								43
44	Remove old workstation & install new workstation, metal								44
45	shelving and counter in medical records.								45
46	Install new shower fixtures, toilet, sink, fauents, mirror,								46
47	shower seat and hand rails.								47
48	2016/2017 RENOVATION (TI MATTOON) - Lotus Living & Dining Roo	2017	20,415	756	27	756		1,260	48
49	Remove old flooring and replace with LVT flooring								49
50	Drywall repairs, paint ceiling and walls.								50
51	Install new storefront doors and hollow metal doors.								51
52	Remove old workstation and install new one.								52
53	Install new signage								53
54	Install new hand sink/faucet.								54
55	Install new countertops and windowsills								55
56	Install new kitchen equipment & serving guide								56
57	2016/2017 RENOVATION (TI MATTOON) - Lotus Nurses Station	2017	17,195	637	27	637		1,274	57
58	Demolition of existing nurses station, shelving, sills, windows								58
59	and remove partition wall.								59
60	Remove old flooring and install new LVT.								60
61	Install new windows; build new metal stud soffit, install								61
62	tackable wall panel; build new metal stud wall, create new								62
63	cased openings, prep and paint walls & ceiling.								63
64	Remove old workstations and install new ones.								64
65	Install new countertops and windowsills								65
66	2016/2017 RENOVATION (TI MATTOON) - Project Management	2017	46,379	1,718	27	1,718		2,477	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,443,249	\$ 137,081		\$ 137,081	\$	\$ 854,447	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 343,817	\$ 52,353	\$ 52,353	\$	Various	\$ 203,089	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	15,000				5	15,000	73
74								74
75	TOTALS	\$ 358,817	\$ 52,353	\$ 52,353	\$		\$ 218,089	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,969,321	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,434	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,434	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,072,536	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	<b>TOTAL</b>				\$ _____			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: \$ 10,743 Description: Dietary, Laundry, Plant, Copier (See WTB)

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	5,403	\$ 367,896	\$ 82	5,403	\$ 367,978	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		1,382	109,041		1,382	109,041	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		6,877	482,283	4,849	6,877	487,132	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				176,989		176,989	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>					83,139	86,254		169,393	13
14	TOTAL			\$	13,662	\$ 1,042,359	\$ 268,174	13,662	\$ 1,310,533	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 **Mattoon Rehabilitation & Health Care Center**

# **0051896**

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 467,603	\$ 479,301	1
2	Cash-Patient Deposits	18,431	18,431	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	946,364	946,364	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		182,479	5
6	Prepaid Insurance	240,682	246,997	6
7	Other Prepaid Expenses	465,070	480,989	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Other Current Assets</b>	23,713	23,713	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,161,863	\$ 2,378,274	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		167,255	13
14	Buildings, at Historical Cost		3,395,306	14
15	Leasehold Improvements, at Historical Cost	23,291	47,943	15
16	Equipment, at Historical Cost	31,597	358,817	16
17	Accumulated Depreciation (book methods)	(45,009)	(1,072,536)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <b>WIP</b> )	202,598	202,598	22
23	Other(specify): <b>Other Long-Term Assets</b>	(3,539)	(359,506)	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 208,938	\$ 2,739,877	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,370,801	\$ 5,118,151	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 984,446	\$ 984,446	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,431	18,431	28
29	Short-Term Notes Payable	357,181	357,181	29
30	Accrued Salaries Payable	191,573	191,573	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,013	60,013	31
32	Accrued Real Estate Taxes(Sch.IX-B)		87,620	32
33	Accrued Interest Payable		8,552	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,611,644	\$ 1,707,816	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,310,606	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,310,606	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,611,644	\$ 5,018,422	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 759,157	\$ 99,729	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,370,801	\$ 5,118,151	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>565,857</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>565,857</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>193,300</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>193,300</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>759,157</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number **Mattoon Rehabilitation & Health Care Center**# **0051896**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,497,296	1
2	Discounts and Allowances for all Levels	(4,917,359)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,579,937	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,711,272	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 5,711,272	8
<b>C. Other Operating Revenue</b>			
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	334,384	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,204	19
20	Radiology and X-Ray		20
21	Other Medical Services	238,595	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 593,183	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	10,134	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,134	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other Revenue</b>	(15,640)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (15,640)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,878,886	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,111,908	31
32	Health Care	2,604,950	32
33	General Administration	1,905,249	33
<b>B. Capital Expense</b>			
34	Ownership	392,181	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,425,062	35
36	Provider Participation Fee	246,236	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,685,586	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	193,300	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 193,300	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,086,661	44
45	Private Pay - Net Inpatient Revenue	1,189,951	45
46	Medicare - Net Inpatient Revenue	(1,907,909)	46
47	Other-(specify) <b>Managed Care</b>	(143,302)	47
48	Other-(specify) <b>Veterans</b>	354,536	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,579,937	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 Mattoon Rehabilitation & Health Care Center

# 0051896

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	1,916	2,167	\$ 82,474	\$ 38.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,192	18,186	525,877	28.92	3
4	Licensed Practical Nurses	28,609	30,113	734,050	24.38	4
5	CNAs & Orderlies	63,473	65,433	898,011	13.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,100	2,140	30,030	14.03	10
11	Social Service Workers	3,253	3,352	57,126	17.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,294	3,593	56,487	15.72	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,836	2,072	97,987	47.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,955	11,686	198,057	16.95	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	941	965	13,160	13.64	31
32	Other Health Care(specify)					32
33	Other(specify)	3,084	3,284	84,853	25.84	33
34	TOTAL (lines 1 - 33)	136,653	142,991	\$ 2,778,112 *	\$ 19.43	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	\$ 460,648	V01-3	35
36	Medical Director	Monthly	19,500	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,730	V103	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	53,375	V11-3	44
45	Social Service Consultant	Monthly	3,458	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 546,711		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	578	24,793	V10-3	51
52	Certified Nurse Assistants/Aides	676	25,281	V10-3	52
53	TOTAL (lines 50 - 52)	1,254	\$ 50,074		53

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

# **0051896**

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

Ending: **12/31/2018**

**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	
Jade Belcher	Administrator	0	\$ 97,987	Workers' Compensation Insurance	\$ 63,946	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	2,079	
				FICA Taxes	223,476	Health Care Worker Background Check (Indicate # of checks performed <u>477</u> )	4,779	
				Employee Health Insurance	94,785	Patient Background Checks		
				Employee Meals		IL Health Care Association	9,768	
				Illinois Municipal Retirement Fund (IMRF)*		Mattoon Chamber of Commers	1,360	
				Other Benefits	15,742	Other Dues	770	
						Other Licenses	55	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,987			Less: Public Relations Expense	(5,065)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,736	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount		\$ 397,949			
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal		\$ 6,963	N/A		\$	Out-of-State Travel	\$
Hamlin & Burton Liability Mgmt	Legal		2,543					
Heyl Royster Voelker & Allen	Legal		2,172					
Other Accural	Legal		17,828				In-State Travel	
CliftonLarsonAllen LLP	Accounting/Cost Report		12,105					
Walnut Creek Mgmt Co LLC	Data Processing		86,513					
Ability Network Inc	Data Processing		796				Seminar Expense	1,884
PointClickCre Technologies	Data Processing		40,502					
Curaspan Health Group	Professional Services		2,478					
Allscripts Healthcare LLC	Professional Services		2,280					
Pinnacle Quality Insight	Professional Services		2,453					
Property Valuation Services	Professional Services		11,120				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 187,753	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,884

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Mattoon Rehabilitation & Health Care Center# 0051896Report Period Beginning: 1/1/2018Ending: 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 Associaiton, \$9,768
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 20,218 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. \$ 246,236  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee 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? 100%  
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