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.

I. IDPH License ID Number: 0049221

Facility Name: Hillsboro Rehabilitation & Health Care Center

Address: 1300 East Tremont Street (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6191 **Fax #** (217) 532-6194

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2008

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kevin Wellen, CPA **Telephone Number:** (314) 925-4446
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/208 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) 600 Washington Ave, Suite 1800, St. Louis, MO 63101
(Telephone) (314) 925-4446 Fax # (314) 925-4350

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

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	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	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,127	12,038	4,197	34,362	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,127	12,038	4,197	34,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.80%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 3,105

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Hillsboro Rehabilitation & Health Care Cente # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		6,045	495,844	501,889		501,889		501,889			1
2	Food Purchase		15,944		15,944		15,944	(1,661)	14,283			2
3	Housekeeping		9,398	101,917	111,315		111,315		111,315			3
4	Laundry		12,413	67,945	80,358		80,358		80,358			4
5	Heat and Other Utilities			119,393	119,393		119,393		119,393			5
6	Maintenance	60,668	15,834	50,404	126,906		126,906	113	127,019			6
7	Other (specify):*											7
8	TOTAL General Services	60,668	59,634	835,503	955,805		955,805	(1,548)	954,257			8
	B. Health Care and Programs											
9	Medical Director					16,500	16,500		16,500			9
10	Nursing and Medical Records	1,891,569	106,526	48,599	2,046,694	(16,500)	2,030,194		2,030,194			10
10a	Therapy											10a
11	Activities	28,499	9,054	56,255	93,808		93,808		93,808			11
12	Social Services	37,519	54	3,275	40,848		40,848		40,848			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,957,587	115,634	108,129	2,181,350		2,181,350		2,181,350			16
	C. General Administration											
17	Administrative	103,967			103,967		103,967		103,967			17
18	Directors Fees											18
19	Professional Services			121,841	121,841		121,841	314,316	436,157			19
20	Dues, Fees, Subscriptions & Promotions			13,273	13,273		13,273	(2,475)	10,798			20
21	Clerical & General Office Expenses	90,555	27,742	435,400	553,697		553,697	(395,429)	158,268			21
22	Employee Benefits & Payroll Taxes			294,633	294,633		294,633		294,633			22
23	Inservice Training & Education			510	510		510		510			23
24	Travel and Seminar			1,782	1,782		1,782		1,782			24
25	Other Admin. Staff Transportation			3,227	3,227		3,227		3,227			25
26	Insurance-Prop.Liab.Malpractice			264,902	264,902		264,902	(238)	264,664			26
27	Other (specify):*											27
28	TOTAL General Administration	194,522	27,742	1,135,568	1,357,832		1,357,832	(83,826)	1,274,006			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,212,777	203,010	2,079,200	4,494,987		4,494,987	(85,374)	4,409,613			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.

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center #0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,751	3,751		3,751	116,543	120,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,106	3,106		3,106	43,734	46,840			32
33	Real Estate Taxes			56,408	56,408		56,408	(600)	55,808			33
34	Rent-Facility & Grounds			170,825	170,825		170,825	(170,825)				34
35	Rent-Equipment & Vehicles			8,314	8,314		8,314		8,314			35
36	Other (specify):* Mortgagae Insurance							8,753	8,753			36
37	**TOTAL Ownership**			242,404	242,404		242,404	(2,395)	240,009			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,457	664,317	842,774		842,774		842,774			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			611	611		611		611			41
42	Provider Participation Fee			242,068	242,068		242,068		242,068			42
43	Other (specify):*	34,552		23,937	58,489		58,489	(58,489)				43
44	**TOTAL Special Cost Centers**	34,552	178,457	930,933	1,143,942		1,143,942	(58,489)	1,085,453			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,247,329	381,467	3,252,537	5,881,333		5,881,333	(146,258)	5,735,075			45

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

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,661)	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	10,821	30		9
10	Interest and Other Investment Income	(9,925)	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	(5,795)	21		18
19	Entertainment	(13,575)	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	(79,257)	21		24
25	Fund Raising, Advertising and Promotional	(23,937)	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	(37,027)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,356)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	14,098		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 14,098		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (146,258)		37

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

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

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

Hillsboro Rehabilitation & Health Care Center

ID# 0049221

Report Period Beginning: 1/1/2018

Ending: 12/31/208

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Dues	$ (2,200)	20	1
2	Chamber of Commerce Dues	(275)	20	2
3				3
4	Marketing Salaries	(34,552)	43	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				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**	(37,027)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,661)	0	0	0	0	0	0	0	0	0	0	(1,661)	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	113	0	0	0	0	0	0	0	0	0	113	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,661)	113	0	0	0	0	0	0	0	0	0	(1,548)	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	8,477	305,839	0	0	0	0	0	0	0	0	314,316	19
20	Fees, Subscriptions & Promotions	(2,475)	0	0	0	0	0	0	0	0	0	0	(2,475)	20
21	Clerical & General Office Expenses	(98,627)	1,046	(297,848)	0	0	0	0	0	0	0	0	(395,429)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(238)	0	0	0	0	0	0	0	0	0	(238)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(101,102)	9,285	7,991	0	0	0	0	0	0	0	0	(83,826)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,763)	9,398	7,991	0	0	0	0	0	0	0	0	(85,374)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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	10,821	98,987	6,735	0	0	0	0	0	0	0	0	116,543	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,925)	56,765	(3,106)	0	0	0	0	0	0	0	0	43,734	32
33	Real Estate Taxes	0	(600)	0	0	0	0	0	0	0	0	0	(600)	33
34	Rent-Facility & Grounds	0	(170,825)	0	0	0	0	0	0	0	0	0	(170,825)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	8,753	0	0	0	0	0	0	0	0	0	8,753	36
37	**TOTAL Ownership**	896	(6,920)	3,629	0	0	0	0	0	0	0	0	(2,395)	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):*	(58,489)	0	0	0	0	0	0	0	0	0	0	(58,489)	43
44	**TOTAL Special Cost Centers**	(58,489)	0	0	0	0	0	0	0	0	0	0	(58,489)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(160,356)	2,478	11,620	0	0	0	0	0	0	0	0	(146,258)	45

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 170,825	TI-Hillsboro, LLC	100.00%	$	$ (170,825)	1
2	V	32	Interest		TI-Hillsboro, LLC	100.00%	50,170	50,170	2
3	V	19	Accounting & Legal		TI-Hillsboro, LLC	100.00%	8,477	8,477	3
4	V	36	Mortgage Insurance		TI-Hillsboro, LLC	100.00%	8,753	8,753	4
5	V	30	Depreciation		TI-Hillsboro, LLC	100.00%	98,987	98,987	5
6	V	32	Amortization of Fiancing Costs		TI-Hillsboro, LLC	100.00%	6,595	6,595	6
7	V	06	Maintenance		TI-Hillsboro, LLC	100.00%	113	113	7
8	V	33	Real Estate Taxes	56,408	TI-Hillsboro, LLC	100.00%	55,808	(600)	8
9	V	26	Insurance	8,476	TI-Hillsboro, LLC	100.00%	8,238	(238)	9
10	V	21	Small equip/Furniutre		TI-Hillsboro, LLC	100.00%	1,046	1,046	10
11	V								11
12	V								12
13	V								13
14	Total			$ 235,709			$ 238,187	$ * 2,478	14

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

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Management Fee	$ 297,848	Tutera Health Care Services	100.00%	$	$ (297,848)	15
16	V	19	Management - Operating	48,842	Tutera Health Care Services	100.00%	354,681	305,839	16
17	V	30	Management - Depreciation		Tutera Health Care Services	100.00%	6,735	6,735	17
18	V	22	Insurance	4,120	CarePlus Insurance, Inc		4,120		18
19	V	25	Mileage Reimbursement	77	Carlinville Rehab & Healthcare		77		19
20	V	10	Nursing Staff	10,498	Carlinville Rehab & Healthcare		10,498		20
21	V	25	Mileage Reimbursement	79	Coulterville Rehb & Healthcare		79		21
22	V	21	Admin Purchsed Services	220	Coulterville Rehb & Healthcare		220		22
23	V	26	Insurance	258,709	LTC Plus Insurance, Inc		258,709		23
24	V	10	Nursing Supplies	127	Walnut Creek Management		127		24
25	V	19	Data Processing/Legal	243	Walnut Creek Management		243		25
26	V	20	Dues/Employee Want Ads/Licenses	1,647	Walnut Creek Management		1,647		26
27	V	21	Small Equip & Postage	6,743	Walnut Creek Management		6,743		27
28	V	22	Employement Expense	615	Walnut Creek Management		615		28
29	V	43	Advertising	151	Walnut Creek Management		151		29
30	V	32	Interest	3,106	JCT Capital, Inc.			(3,106)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 633,025			$ 644,645	$ * 11,620	39

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

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Tutera Investments, Inc.	99%	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 Healt	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 Cent	McLeansboro, IL	Vicotry 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			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Assisted	Laurinburg, 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 - Hillsboro LLC	Hillsboro 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 Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Cente	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibl MO	Walnut Creek New En	Kansas City, MO	Mgmt Company	19
20			Holly Hill Rehab & Health Care CEnter	Sulphur, LA	Tutera Investments In	Kansas City, MO	Mgmt Company	20
21			Rosewood Rehab & Health Care Center	Lake Charles, LA	JCT Capital	Kansas City, MO	Mgmt Company	21
22			St. Paul's Senior Community	Belleville, IL	Tutera Group Inc	Kansas City, MO	Mgmt Company	22
23			Greenfield Manor	Greenfield, IA	LTC Plus Insurance Ir	Kansas City, MO	Insurance Company	23
24			Griswold Care Center	Griswold, IA	Residence at Pleasonto	Pleasontan	Al/IL	24
25			Moweaqua Rehb & Health Care Center	Moweaqua, IL	Mt Ayr	Mt.Ayr, IA	AL/IL	25
26			Stratford Rehab & Health Care Center	Overland Park, KS	Missiona Chateua Seni	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 Hillsboro Rehabilitation & Health Care Cen # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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 [X] NO [ ]

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

Name of Related Organization: Tutera Health Care Services
Street Address: 7611 State Line Road
City / State / Zip Code: Kansas City, Missouri 64114
Phone Number: (816-444-0900
Fax Number: (816-822-0081

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fee - Operating	Direct Costs	193,500,518	48	$ 12,214,787	$ 8,837,460	5,618,722	$ 354,684	1
2	30	Management Fee - Depreciation	Direct Costs	193,500,518	48	231,947		5,618,722	6,735	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		$ 361,419	25

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Cent # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 1,714,545			$ 50,655	1
2	Amortize HUD Financing Costs		X								6,595	2
3	Interest Income Offset										(485)	3
4												4
5												5
	Working Capital											
6	JCT Capital	X					994,000	692,239		0.0110	3,106	6
7	Interest Income Offset	X									(9,925)	7
8	Related Party Offset										(3,106)	8
9	TOTAL Facility Related						$ 994,000	$ 2,406,784			$ 46,840	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 994,000	$ 2,406,784			$ 46,840	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 8,753 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.)

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,902	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.)		$ 55,302	2
3. Under or (over) accrual (line 2 minus line 1).		$ (600)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,408	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.		$ 55,808	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	54,950	8
	2014	58,486	9
	2015	57,194	10
	2016	55,902	11
	2017	55,302	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:

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 Hillsboro Rehabilitation & Health Care Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0049221

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-12-256-022	Long-Term Care	$ 55,302.18	$ 55,302.18
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,302.18	$ 55,302.18

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.

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long-Term Care	12,500	2008	$ 240,000	1
2					2
3	TOTALS	12,500		$ 240,000	3

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		2008	1975	$ 2,460,000	$ 63,077	39	$ 63,077	$	$ 688,590	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2008 IMPROVEMENTS			2008	12,130	708	10	708		12,130	9
10	2009 IMPROVEMENTS			2009	1,309	87	15	87		936	10
11	2010 IMPROVEMENTS			2010	2,042	170	12	170		1,432	11
12	ASPHALT			2014	21,500	2,150	10	2,150		9,675	12
13	REMOVE AND REPLACE CARPETING IN ENTRYWAY			2014	9,800	1,225	8	1,225		8,104	13
14	WOOD PLANK VINYL & COVER BASE-ENTIRE FACILITY HALLW			2015	42,652	4,265	10	4,265		15,995	14
15	REMOVE WALLPAPER & PAINT HANDRAILS-ENTIRE FACILITY			2015	36,765	3,677	10	3,677		13,481	15
16											16
17	Home Office Depreciation					6,735		6,735			17
18											18
19	2011 IMPROVEMENTS (TI HILLSBORO)			2011	250,521	16,536	Various	16,536		124,250	19
20	2012 IMPROVEMENTS (TI HILLSBORO)			2012	58,858	2,792	Various	2,792		18,554	20
21	REMODEL SHOWER ON 300 HALL - TORN DOWN TO STUDS. ENL			2016	53,119	3,541	15	3,541		10,328	21
22	WITH NEW PLUMBING, DRY WALL, TILE & PAINT										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

*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

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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	$ 157,344	$ 15,331	$ 15,331	$	Various	$ 100,191	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	300,000				7	300,000	73
74								74
75	TOTALS	$ 457,344	$ 15,331	$ 15,331	$		$ 400,191	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)	$ 3,646,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,294	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,294	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)	$ 1,303,666	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.

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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	$

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: $ 8,314 Description: Dietary, Laundry, Housekeeping, 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	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.

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-3	hrs	$	3,697	$ 288,671	$	3,697	$ 288,671	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		715	50,758		715	50,758	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		3,156	234,969	221	3,156	235,190	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				103,750		103,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB					89,919	74,486		164,405	13
14	TOTAL			$	7,568	$ 664,317	$ 178,457	7,568	$ 842,774	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 Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/208 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 409,943	$ 415,985	1
2	Cash-Patient Deposits	54,769	54,769	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	774,909	774,959	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		99,185	5
6	Prepaid Insurance	202,194	206,194	6
7	Other Prepaid Expenses	363,396	364,123	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	2,130	2,130	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,807,341	$ 1,917,345	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		240,000	13
14	Buildings, at Historical Cost		2,815,841	14
15	Leasehold Improvements, at Historical Cost	126,198	132,855	15
16	Equipment, at Historical Cost	26,506	457,344	16
17	Accumulated Depreciation (book methods)	(77,992)	(1,303,666)	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	(12,823)	(1,099,107)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,889	$ 1,243,267	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,869,230	$ 3,160,612	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 678,070	$ 678,070	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,769	54,769	28
29	Short-Term Notes Payable	692,239	692,239	29
30	Accrued Salaries Payable	157,605	157,605	30
31	Accrued Taxes Payable (excluding real estate taxes)	97,769	97,769	31
32	Accrued Real Estate Taxes(Sch.IX-B)		56,408	32
33	Accrued Interest Payable		4,143	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	(1,223)	(1,223)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,679,229	$ 1,739,780	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,714,545	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)**	$	$ 1,714,545	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,679,229	$ 3,454,325	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 190,001	$ (293,713)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,869,230	$ 3,160,612	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 122,096	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 122,096	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	67,905	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)**	$ 67,905	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)**	$ 190,001	24 *

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

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,658,641	1
2	Discounts and Allowances for all Levels	(2,299,180)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,359,461	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,178,257	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,178,257	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	187,270	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,512	19
20	Radiology and X-Ray		20
21	Other Medical Services	133,673	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 415,455	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,925	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,925	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(13,860)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (13,860)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,949,238	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	955,805	31
32	Health Care	2,181,350	32
33	General Administration	1,357,832	33
	B. Capital Expense		
34	Ownership	242,404	34
	C. Ancillary Expense		
35	Special Cost Centers	901,874	35
36	Provider Participation Fee	242,068	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,881,333	40
41	**Income before Income Taxes (line 30 minus line 40)****	67,905	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 67,905	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,684,636	44
45	Private Pay - Net Inpatient Revenue	1,279,255	45
46	Medicare - Net Inpatient Revenue	(1,399,718)	46
47	Other-(specify) Managed Care	(204,712)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,359,461	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,832	1,888	$ 69,913	$ 37.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,398	12,985	319,744	24.62	3
4	Licensed Practical Nurses	31,016	32,737	717,552	21.92	4
5	CNAs & Orderlies	59,025	61,246	771,832	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	613	621	10,602	17.07	9
10	Activity Assistants	1,744	1,744	17,897	10.26	10
11	Social Service Workers	1,899	2,063	37,519	18.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,195	3,335	60,668	18.19	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,864	2,078	103,967	50.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,234	5,686	90,555	15.93	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	934	1,082	12,528	11.58	31
32	Other Health Care(specify)					32
33	Other(specify)	1,718	1,850	34,552	18.68	33
34	TOTAL (lines 1 - 33)	121,472	127,315	$ 2,247,329 *	$ 17.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 495,844	V01-3	35
36	Medical Director	Monthly	16,500	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,110	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	53,261	V11-3	44
45	Social Service Consultant	Monthly	3,275	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 577,990		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	106	$ 8,221	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	12	549	10-3	52
53	TOTAL (lines 50 - 52)	118	$ 8,770		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashley Blevins	Administrator	0	$ 103,967
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,967

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Offices	Legal	$ 6,600
Other Accural	Legal	12,087
CliftonLarsonAllen LLP	Accounting/Cost Report	13,875
PointClickCare Technologies Inc	Data Processing	29,300
Walnut Creek Mgmt Co LLC	Data Processing	53,473
Allscripts Healthcare LLC	Professional Services	2,280
Pinnacle Quality Insight	Professional Services	2,058
Property Valuation Services	Professional Services	100
Curaspan Health Group	Professional Services	2,068
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 121,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,202
Unemployment Compensation Insurance	
FICA Taxes	186,639
Employee Health Insurance	47,629
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	6,163
TOTAL (agree to Schedule V, line 22, col.8)	$ 294,633

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,420
Health Care Worker Background Check	
(Indicate # of checks performed 64)	646
Patient Background Checks	
IL Health Care Association	7,320
State Journal Register	379
Other Dues and Subscriptions	1,441
Other Licenses	77
Less: Public Relations Expense	(2,475)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,798

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,782
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,782

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hillsboro Rehabilitation & Health Care Center # 0049221 Report Period Beginning: 1/1/2018 Ending: 12/31/208

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, $7,321**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **34,101** 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 fo
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 Departmen
during this cost report period. $ **242,068**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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? **No**
e. Are all vehicles stored at the nursing home during the night and all othe
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
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