FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051870

Facility Name: Dixon Rehab HCC

Address: 800 Division Street (Number) Dixon (City) 61021 (Zip Code)

County: Lee

Telephone Number: (815) 284-3393 **Fax #** (815) 284-2066

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2008

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) 925-4300
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 1/1/2020 to 12/31/2020 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) CliftonLarsonAllen LLP, 600 Washington Ave, Suite 1800, St. Louis, MO 63101
(Telephone) (314) 925-4300 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 Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 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	97	Skilled (SNF)	97	35,502	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	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	14,712	6,411	6,360	27,483	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,712	6,411	6,360	27,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.41%

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 5/1/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 3,126

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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		3,639	508,216	511,855		511,855		511,855			1
2	Food Purchase		9,602		9,602		9,602	(638)	8,964			2
3	Housekeeping		15,898	114,555	130,453		130,453		130,453			3
4	Laundry		5,287	76,460	81,747		81,747		81,747			4
5	Heat and Other Utilities			112,671	112,671		112,671		112,671			5
6	Maintenance	82,232	18,180	59,473	159,885		159,885		159,885			6
7	Other (specify):*											7
8	**TOTAL General Services**	82,232	52,606	871,375	1,006,213		1,006,213	(638)	1,005,575			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,201,136	121,444	193,827	2,516,407		2,516,407	(15,000)	2,501,407			10
10a	Therapy											10a
11	Activities	93,309	9,176	4,436	106,921		106,921		106,921			11
12	Social Services	41,766		4,350	46,116		46,116		46,116			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,336,211	130,620	220,613	2,687,444		2,687,444	(15,000)	2,672,444			16
	C. General Administration											
17	Administrative	98,804		379,886	478,690		478,690	(56,274)	422,416			17
18	Directors Fees											18
19	Professional Services			119,412	119,412		119,412	(64,348)	55,064			19
20	Dues, Fees, Subscriptions & Promotions			21,090	21,090		21,090	(2,098)	18,992			20
21	Clerical & General Office Expenses	154,761	35,495	90,124	280,380		280,380	(45,915)	234,465			21
22	Employee Benefits & Payroll Taxes			358,543	358,543		358,543		358,543			22
23	Inservice Training & Education			4,756	4,756		4,756		4,756			23
24	Travel and Seminar			21,572	21,572		21,572		21,572			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			103,430	103,430		103,430		103,430			26
27	Other (specify):*											27
28	**TOTAL General Administration**	253,565	35,495	1,098,813	1,387,873		1,387,873	(168,635)	1,219,238			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,672,008	218,721	2,190,801	5,081,530		5,081,530	(184,273)	4,897,257			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 Dixon Rehab HCC #0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,645	55,645		55,645	24,342	79,987			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,659	29,659		29,659	166,255	195,914			32
33	Real Estate Taxes			53,044	53,044		53,044		53,044			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			2,368	2,368		2,368		2,368			35
36	Other (specify):*											36
37	**TOTAL Ownership**			440,716	440,716		440,716	(109,403)	331,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		319,679	426,213	745,892		745,892		745,892			39
40	Barber and Beauty Shops			168	168		168		168			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,678	201,678		201,678		201,678			42
43	Other (specify):* **Marketing**	44,532		35,011	79,543		79,543	(79,543)				43
44	**TOTAL Special Cost Centers**	44,532	319,679	663,070	1,027,281		1,027,281	(79,543)	947,738			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,716,540	538,400	3,294,587	6,549,527		6,549,527	(373,219)	6,176,308			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 Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(253)	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	(6,250)	21		18
19	Entertainment	(25,228)	21		19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	11,643	21		24
25	Fund Raising, Advertising and Promotional	(27,252)	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	(61,607)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (109,447)		$	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)	(263,772)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (263,772)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (373,219)		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

Dixon Rehab HCC

ID# 0051870

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Portion of Dues	$ (1,671)	20	1
2	PAC Dues	(427)	20	2
3	Marketing Salaries	(44,532)	43	3
4	Marketing Benefits	(7,759)	43	4
5	Miscellaneous Income	(6,580)	21	5
6	Vending Machine Income	(638)	02	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**	(61,607)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dixon Rehab HCC # 0051870 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(638)	0	0	0	0	0	0	0	0	0	0	(638)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(638)	0	0	0	0	0	0	0	0	0	0	(638)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	16
	C. General Administration													
17	Administrative	0	0	(56,274)	0	0	0	0	0	0	0	0	(56,274)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	200	(64,548)	0	0	0	0	0	0	0	0	(64,348)	19
20	Fees, Subscriptions & Promotions	(2,098)	0	0	0	0	0	0	0	0	0	0	(2,098)	20
21	Clerical & General Office Expenses	(26,915)	0	(19,000)	0	0	0	0	0	0	0	0	(45,915)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,013)	200	(139,822)	0	0	0	0	0	0	0	0	(168,635)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,651)	200	(154,822)	0	0	0	0	0	0	0	0	(184,273)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dixon Rehab HCC **#** 0051870 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	21,246	3,096	0	0	0	0	0	0	0	0	24,342	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(253)	196,167	(29,659)	0	0	0	0	0	0	0	0	166,255	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(253)	(82,587)	(26,563)	0	0	0	0	0	0	0	0	(109,403)	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):*	(79,543)	0	0	0	0	0	0	0	0	0	0	(79,543)	43
44	**TOTAL Special Cost Centers**	(79,543)	0	0	0	0	0	0	0	0	0	0	(79,543)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(109,447)	(82,387)	(181,385)	0	0	0	0	0	0	0	0	(373,219)	45

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 300,000	Ti-Dixon Illinois, LLC	100.00%	$	$ (300,000)	1
2	V	32	Interest		Ti-Dixon Illinois, LLC	100.00%	196,167	196,167	2
3	V	19	Legal Fees		Ti-Dixon Illinois, LLC	100.00%	200	200	3
4	V	30	Depreciation		Ti-Dixon Illinois, LLC	100.00%	21,246	21,246	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 300,000			$ 217,613	$ * (82,387)	14

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	22	Insurance	$ 3,522	CarePlus Health Plus		$ 3,522	$	15
16	V	22	Insurance	85,443	Cost Plus Insurance		85,443		16
17	V	26	Insurance	89,417	LTC Plus Insurance, Inc.		89,417		17
18	V	17	Management-Operating	379,886	Tutera Health Care Service		323,612	(56,274)	18
19	V	19	Management-Data Processing	64,548	Tutera Health Care Service			(64,548)	19
20	V	30	Management-Depreciation		Tutera Health Care Service		3,096	3,096	20
21	V	10	Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000)	21
22	V	21	Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000)	22
23	V	32	Interest	29,659	Tutera Investments			(29,659)	23
24	V	10	Nursing Admin - SM Equip	1,858	Walnut Creek Management Company, LLC		1,858		24
25	V	24	Travel & Seminar	2,165	Walnut Creek Management Company, LLC		2,165		25
26	V	43	Marketing	256	Walnut Creek Management Company, LLC		256		26
27	V	23	Inservice Training	30	Walnut Creek Management Company, LLC		30		27
28	V	19	Purchased Svs/Data Processing	7,300	Walnut Creek Management Company, LLC		7,300		28
29	V	20	Help Wanted Ads & Licenses	5,271	Walnut Creek Management Company, LLC		5,271		29
30	V	21	Supplies, Sm Equip, Postage	13,295	Walnut Creek Management Company, LLC		13,295		30
31	V	21	Employment Expense	486	Critical Care Rx, LLC		486		31
32	V	10	Pharmacy Consultant	6,443	Critical Care Rx, LLC		6,443		32
33	V	39	Drugs	89,429	Critical Care Rx, LLC		89,429		33
34	V	39	IV Therapy & Supplies	12,576	Critical Care Rx, LLC		12,576		34
35	V	21	Employee Entertainment	154	Bethany Health Care		154		35
36	V								36
37	V								37
38	V								38
39	Total			$ 825,738			$ 644,353	$ * (181,385)	39

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Tutera Investments, LLC	99%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Liv	Overland Park, KS	IL/AL	1
2	JCT FLP, LLC	1%	Bethany Rehab & Health Care Center	DeKlb, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3			Carlinville Rehab & Health Care Center	Carlinville, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Lamar Court Assisted I	Overland Park, KS	AL	5
6			Auburn Rehab & Health Care Center	Auburn, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted L	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Liv	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Senio	Prairie Village, KS	AL/IL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Kansas City, MO	AL/IL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL				14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Ser	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New Eng	Kansas City, MO	Mgmt Company	19
20			St. Paul's Senior Community	Belleville, IL	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Tutera Investments, LL	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Overland Park, KS	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Belton, MO	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Kansas City, MO	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Kansas City, MO				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	17	Management Fee- Operating	Direct Costs	287,210,821	71	$ 15,078,459	$ 10,830,799	6,164,022	$ 323,609	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		6,164,022	3,095	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 15,222,689	$ 10,830,799		$ 326,704	25

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tutera Group Inc	x		Note Payable (TI Dixon)			$	$ 3,240,588		0.0700	$ 196,167	1
2	Interest Income Offset										(253)	2
3												3
4												4
5												5
	Working Capital											
6	Tutera Investments	x		Note Payable			3,187,657	2,678,531		0.0100	29,647	6
7	Other Interest										12	7
8	Related Party Interest Offset										(29,659)	8
9	TOTAL Facility Related						$ 3,187,657	$ 5,919,119			$ 195,914	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,187,657	$ 5,919,119			$ 195,914	15

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

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

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,675	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.)		$ 51,081	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,406	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,638	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.		$ 53,044	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	45,924	8
	2016	47,832	9
	2017	49,058	10
	2018	50,638	11
	2019	51,081	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dixon Rehab HCC COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051870

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-08-04-376-011	Long-Term Care	$ 51,081.60	$ 51,081.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,081.60	$ 51,081.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,700 B. General Construction Type: Exterior Brick Frame Brick 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 [X] 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	28,700	2002	$ 92,000	1
2					2
3	TOTALS	28,700		$ 92,000	3

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	97		2002	1973	$ 822,167	$ 21,246	27	$ 21,246	$	$ 696,061	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door Alarm System			2014	15,105	660	10	660		12,795	9
10	Generator Replacement			2014	30,599		5			30,599	10
11	Courtyard Sidewalk & Patio			2015	11,544	770	15	770		4,233	11
12	Flat Roof			2015	34,694	1,735	20	1,735		9,396	12
13	100 Hall shower torn down to stufds, expanded, plumbing replaced, tile rep			2016	15,259	1,877	7	1,877		10,566	13
14	dry wall replaced and paint										14
15	Entrance Roof Replacement			2016	24,670	897		897		3,364	15
16	LED Lights-Bldg Perimeter			2017	9,918	992	10	992		3,471	16
17	Hand Rails Hallways 100, 200 & 300			2018	22,300	1,487	15	1,487		3,592	17
18	Lighting - 100, 200 & 300 Hallways			2018	5,898	393	15	393		950	18
19	Canopy renovation & Window Repair			2018	7,225	482	15	482		1,165	19
20	Painting - 100, 200 & 300 Hallways; Room 302 and 305; Entry way;										20
21	conference room; dinning room and nurse station			2018	56,933	3,796	15	3,796		9,173	21
22	Carpet & Vinyl Flooring & cover base - 100, 200 & 300 Hallways, Room 302										22
23	Room 305, conference room, dinning room and nurse station			2018	56,596	3,773	15	3,773		9,118	23
24	Renovation - Expand Entryway: Construction, drywall, paint, flooring			2018	27,256	1,817	15	1,817		4,391	24
25	Home Office Allocation					3,096		3,096			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 Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	N/A		$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,140,164	$ 43,020		$ 43,020	$	$ 798,874	70

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 190,671	$ 24,542	$ 24,542	$		$ 95,604	71
72	Current Year Purchases	14,000	1,000	1,000			1,000	72
73	Fully Depreciated Assets	92,034	388	388			92,034	73
74								74
75	TOTALS	$ 296,705	$ 25,930	$ 25,930	$		$ 188,638	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Ford Van	2012	$ 13,000	$	$	$	4	$ 13,000	76
77		Ford Transit 350 XL Van	2018	55,185	11,037	11,037		5	28,505	77
78										78
79										79
80	TOTALS			$ 68,185	$ 11,037	$ 11,037	$		$ 41,505	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,597,054	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 79,987	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 79,987	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)	$ 1,029,017	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 Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 2,368 Description: Dishwasher, Nursing Equip, 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 Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V39-03	hrs	$	2,473	$ 137,547	$	2,473	$ 137,547	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		1,474	103,329		1,474	103,329	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		2,872	164,267	1,110	2,872	165,377	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescrpts				87,871		87,871	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapy	V39-03			80	4,626		80	4,626	12
13	Other (specify): See WTB	V39-02,03				16,444	230,698		247,142	13
14	TOTAL			$	6,899	$ 426,213	$ 319,679	6,899	$ 745,892	14

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 404,498	$ 408,071	1
2	Cash-Patient Deposits	47,914	47,914	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	263,682	263,682	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,648	109,648	6
7	Other Prepaid Expenses	352,305	352,305	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	428,539	428,539	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,606,586	$ 1,610,159	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		92,000	13
14	Buildings, at Historical Cost		822,167	14
15	Leasehold Improvements, at Historical Cost	317,997	317,997	15
16	Equipment, at Historical Cost	290,255	364,890	16
17	Accumulated Depreciation (book methods)	(233,419)	(1,029,017)	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 **Other Fixed Assets**	(42,580)	(40,919)	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 332,253	$ 527,118	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,938,839	$ 2,137,277	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 645,378	$ 645,378	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,914	47,914	28
29	Short-Term Notes Payable	2,678,531	2,678,531	29
30	Accrued Salaries Payable	137,522	137,522	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,117	34,117	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,638	50,638	32
33	Accrued Interest Payable			33
34	Deferred Compensation	664,548	664,548	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,258,648	$ 4,258,648	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,240,588	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,240,588	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,258,648	$ 7,499,236	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,319,809)	$ (5,361,959)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,938,839	$ 2,137,277	48

***(See instructions.)**

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,402,152)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,402,152)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	82,343	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)**	$ 82,343	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,319,809)	24 *

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

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,262,134	1
2	Discounts and Allowances for all Levels	(2,193,518)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,068,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,869,643	6
7	Oxygen	12,763	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,882,406	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	(934)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	180,712	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,129	19
20	Radiology and X-Ray	3,506	20
21	Other Medical Services	50,296	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 247,709	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	253	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 253	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	7,218	28
28a	COVID-19 PHE Funding	425,668	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 432,886	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,631,870	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,006,213	31
32	Health Care	2,687,444	32
33	General Administration	1,387,873	33
	B. Capital Expense		
34	Ownership	440,716	34
	C. Ancillary Expense		
35	Special Cost Centers	825,603	35
36	Provider Participation Fee	201,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,549,527	40
41	**Income before Income Taxes (line 30 minus line 40)****	82,343	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 82,343	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,699,570	44
45	Private Pay - Net Inpatient Revenue	1,087,040	45
46	Medicare - Net Inpatient Revenue	(905,293)	46
47	Other-(specify) Managed Care	(166,085)	47
48	Other-(specify) Hospice	353,384	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,068,616	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	1,036	1,060	$ 47,636	$ 44.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,557	16,969	633,891	37.36	3
4	Licensed Practical Nurses	16,545	18,168	555,213	30.56	4
5	CNAs & Orderlies	53,220	55,854	945,686	16.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,978	2,038	35,204	17.27	9
10	Activity Assistants	4,498	4,673	58,105	12.43	10
11	Social Service Workers	2,080	2,239	41,766	18.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,379	3,913	82,232	21.02	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,904	2,080	98,804	47.50	20
21	Assistant Administrator					21
22	Other Administrative	216	216	2,695	12.48	22
23	Office Manager					23
24	Clerical	8,317	9,126	154,761	16.96	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	1,163	16,015	13.77	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,924	2,122	44,532	20.99	33
34	TOTAL (lines 1 - 33)	111,595	119,621	$ 2,716,540 *	$ 22.71	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	$ 8,413	V01-3	35
36	Medical Director	Monthly	18,000	V09-3	36
37	Medical Records Consultant	Monthly	1,796	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,457	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	4,350	V11-3	43
44	Activity Consultant	Monthly	3,530	V12-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 42,546		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,141	$ 74,724	V10-3	50
51	Licensed Practical Nurses	825	51,922	V10-3	51
52	Certified Nurse Assistants/Aides	526	16,298	V10-3	52
53	TOTAL (lines 50 - 52)	2,491	$ 142,944		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina Miller	Administrator	0	$ 98,804
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,804

B. Administrative - Other

Description	Amount
Tutera Health Care Services - Management Fee	$ 379,886
TOTAL (agree to Schedule V, line 17, col. 3)	$ 379,886
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Reverse Legal Accruals	Legal Services	$ (2,425)
Daniel Maher Law Offices	Legal Services	1,560
Heyl Royster Coelker & Allen	Legal Services	4,653
CliftonLarsonAllen	Taxes/Cost Reports	4,830
PointClickCare Technologies	Data Processing	28,395
Walnut Creek Mgmt Co LLC	Data Processing-Billing	71,146
Providigm LLC	Data Processing	2,100
Pinnacle Quality Insight	Professional Services	530
Allscripts Healthcare LLC	Professional Services	8,450
Property Valuation Services	Professional Services	100
Net Accruals	Professional Svs/DP	73
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 119,412

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,037
Unemployment Compensation Insurance	
FICA Taxes	209,817
Employee Health Insurance	89,761
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	2,928
TOTAL (agree to Schedule V, line 22, col.8)	$ 358,543

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,377
Health Care Worker Background Check	
(Indicate # of checks performed 79)	786
IL Health Care Association	6,080
IHAC PAC	427
Other Dues and Subscriptions	2,672
Lee County Health Dept.	450
Other Licences	298
Less: Public Relations Expense	(2,098)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,992

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Interim DON - Lodging & Meals	16,858
Interim Operations - Lodging	4,231
Mileage for Inservice	233
Seminar Expense	
INHAA, Springfield, IL - Adminstrator	250
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,572

**See instructions.

Facility Name & ID Number Dixon Rehab HCC # 0051870 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Association $6,080**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,181** 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. $ **201,678**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.