		FOR BHF USE					

LL1

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.

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

I. IDPH License ID Number: 0051292

Facility Name: Hamilton Memorial Rehab HCC

Address: 609 S Marshall Ave (Number) McLeansboro (City) 62859 (Zip Code)

County: Hamilton

Telephone Number: (618) 643-2325 **Fax #** (618) 643-3528

HFS ID Number:

Date of Initial License for Current Owners: 5/17/2011

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 Hamilton Memorial Rehab HCC # 0051292 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	60	Skilled (SNF)	60	21,960	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	60	TOTALS	60	21,960	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	9,519	4,184	1,057	14,760	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,519	4,184	1,057	14,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.21%

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 5/17/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/17/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 988

Medicare Intermediary Wisonsin 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 Hamilton Memorial Rehab HCC # 0051292 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	186,317	29,695	6,666	222,678		222,678		222,678			1
2	Food Purchase		77,716		77,716		77,716	(92)	77,624			2
3	Housekeeping	85,264	16,312		101,576		101,576		101,576			3
4	Laundry	37,195	8,168	193	45,556		45,556		45,556			4
5	Heat and Other Utilities			105,131	105,131		105,131		105,131			5
6	Maintenance	30,390	4,848	31,922	67,160		67,160		67,160			6
7	Other (specify):*											7
8	**TOTAL General Services**	339,166	136,739	143,912	619,817		619,817	(92)	619,725			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,075,539	52,963	26,148	1,154,650		1,154,650	(15,000)	1,139,650			10
10a	Therapy											10a
11	Activities	44,853	2,610	3,988	51,451		51,451		51,451			11
12	Social Services	35,218		2,816	38,034		38,034		38,034			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,155,610	55,573	44,952	1,256,135		1,256,135	(15,000)	1,241,135			16
	C. General Administration											
17	Administrative	81,388		146,537	227,925		227,925	21,963	249,888			17
18	Directors Fees											18
19	Professional Services			70,981	70,981		70,981	(23,914)	47,067			19
20	Dues, Fees, Subscriptions & Promotions			15,690	15,690		15,690	(1,416)	14,274			20
21	Clerical & General Office Expenses	64,829	16,480	57,333	138,642		138,642	(27,305)	111,337			21
22	Employee Benefits & Payroll Taxes			223,480	223,480		223,480		223,480			22
23	Inservice Training & Education			1,075	1,075		1,075		1,075			23
24	Travel and Seminar			147	147		147		147			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,594	63,594		63,594		63,594			26
27	Other (specify):*											27
28	**TOTAL General Administration**	146,217	16,480	578,837	741,534		741,534	(30,672)	710,862			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,640,993	208,792	767,701	2,617,486		2,617,486	(45,764)	2,571,722			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 Hamilton Memorial Rehab HCC #0051292 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			18,850	18,850		18,850	16,120	34,970			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,199	12,199		12,199	(12,199)				32
33	Real Estate Taxes			12,299	12,299		12,299		12,299			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			821	821		821		821			35
36	Other (specify):*											36
37	**TOTAL Ownership**			224,169	224,169		224,169	(176,079)	48,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,990	246,405	401,395		401,395		401,395			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,125	116,125		116,125		116,125			42
43	Other (specify):* **Marketing**	20,395		25,070	45,465		45,465	(45,465)				43
44	**TOTAL Special Cost Centers**	20,395	154,990	387,600	562,985		562,985	(45,465)	517,520			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,661,388	363,782	1,379,470	3,404,640		3,404,640	(267,308)	3,137,332			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 Hamilton Memorial Rehab HCC # 0051292 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	(92)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(16,514)	21		19
20	Contributions	(250)	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	8,762	21		24
25	Fund Raising, Advertising and Promotional	(20,168)	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	(27,016)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,278)		$	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)	(212,030)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (212,030)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (267,308)		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

Hamilton Memorial Rehab HCC

ID# 0051292

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (288)	20	1
2	Marketing Salaries	(20,395)	43	2
3	Marketing Benefits	(4,902)	43	3
4	Miscellaneous Income	(303)	21	4
5	Lobbying Portion of Dues	(1,128)	20	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**	(27,016)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 **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	(92)	0	0	0	0	0	0	0	0	0	0	(92)	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**	(92)	0	0	0	0	0	0	0	0	0	0	(92)	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	21,963	0	0	0	0	0	0	0	0	21,963	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,086	(27,000)	0	0	0	0	0	0	0	0	(23,914)	19
20	Fees, Subscriptions & Promotions	(1,416)	0	0	0	0	0	0	0	0	0	0	(1,416)	20
21	Clerical & General Office Expenses	(8,305)	0	(19,000)	0	0	0	0	0	0	0	0	(27,305)	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**	(9,721)	3,086	(24,037)	0	0	0	0	0	0	0	0	(30,672)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,813)	3,086	(39,037)	0	0	0	0	0	0	0	0	(45,764)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	14,509	1,611	0	0	0	0	0	0	0	0	16,120	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	(12,199)	0	0	0	0	0	0	0	0	(12,199)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	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**	0	(165,491)	(10,588)	0	0	0	0	0	0	0	0	(176,079)	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):*	(45,465)	0	0	0	0	0	0	0	0	0	0	(45,465)	43
44	**TOTAL Special Cost Centers**	(45,465)	0	0	0	0	0	0	0	0	0	0	(45,465)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,278)	(162,405)	(49,625)	0	0	0	0	0	0	0	0	(267,308)	45

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	$ 180,000	TI-McLeansboro	100.00%	$	$ (180,000)	1
2	V	19	Legal/Taxes Other		TI-McLeansboro	100.00%	3,086	3,086	2
3	V	30	Depreciation		TI-McLeansboro	100.00%	14,509	14,509	3
4	V								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			$ 180,000			$ 17,595	$ * (162,405)	14

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

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	$ 3,021	CarePlus Health Plus		$ 3,021	$	15
16	V	22	Insurance	59,057	Cost Plus Insurance		59,057		16
17	V	26	Insurance	55,309	LTC Plus Insurance, Inc.		55,309		17
18	V	17	Management-Operating	146,537	Tutera Health Care Service		168,500	21,963	18
19	V	19	Management-Data Processing	27,000	Tutera Health Care Service			(27,000)	19
20	V	30	Management-Depreciation		Tutera Health Care Service		1,611	1,611	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	12,199	JCT Capital/Tutera Investments			(12,199)	23
24	V	24	Travel & Seminar	127	Walnut Creek Management Company, LLC		127		24
25	V	19	Purchased Svs/Data Processing	5,886	Walnut Creek Management Company, LLC		5,886		25
26	V	20	Help Wanted Ads & Licenses	1,365	Walnut Creek Management Company, LLC		1,365		26
27	V	21	Supplies, Sm Equip, Postage	4,400	Walnut Creek Management Company, LLC		4,400		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 348,901			$ 299,276	$ * (49,625)	39

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

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	JCT FLP, LLC	99%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Liv	Overland Park, KS	IL/AL	1
2	JCT INV, LLC	1%	Bethany Rehab & Health Care Center	Auburn, 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	DeKalb, IL	Lamar Court Assisted I	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Crystal Lake, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	Dixon, IL	Rose Estates Assisted L	Overland Park, KS	AL	7
8			Auburn Rehab & Health Care Center	Auburn, 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 Seni	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	Sulphur, LA	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Moweaqua Rehab & Health Care Center	Lake Charles, LA	Tutera Investments, LI	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Belleville, IL	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Greenfield, IA	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Griswold, IA	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Moweaqua, IL				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 Hamilton Memorial Rehab HCC # 0051292 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	19	Management Fee- Operating	Direct Costs	287,210,821	71	$ 15,078,459	$ 10,830,799	3,209,533	$ 168,499	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		3,209,533	1,612	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		$ 170,111	25

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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							$	$			$	1
2	Tutera Investments	X		Note Payable			1,303,850	1,166,042		0.0100	12,199	2
3	Related Party Offset										(12,199)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,303,850	$ 1,166,042			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,303,850	$ 1,166,042			$	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 Hamilton Memorial Rehab HCC # 0051292 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.**	$ 13,616	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.)		$ 12,957	2
3. Under or (over) accrual (line 2 minus line 1).		$ (659)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 12,958	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.		$ 12,299	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	12,883	8
	2016	13,034	9
	2017	13,087	10
	2018	12,957	11
	2019	12,957	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 Hamilton Memorial Rehab HCC COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 0051292

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.	07-030-005-25	Long-Term Care	$ 12,957.28	$ 12,957.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 12,957.28	$ 12,957.28

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 Hamilton Memorial Rehab HCC # 0051292 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,169 B. General Construction Type: Exterior Brick Frame Wood/Steel 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	15,169	2011	$ 28,500	1
2					2
3	TOTALS	15,169		$ 28,500	3

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	60		2011	1970	$ 399,000	$ 14,509	27	$ 14,509	$	$ 139,653	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS 2011 - THERAPY ROOM			2011	96,066	9,607	10	9,607		86,459	9
10	BUILDING IMPROVEMENTS 2011 - LAUNDRY ROOM			2011	22,902	2,290	10	2,290		20,612	10
11	BREEZEWAY RENOVATION (WINDOWS)			2012	10,460	729	15	729		5,811	11
12	FLOORING			2014	17,174	1,014	15	1,014		8,554	12
13	SPRINKLER SYSTEM PIPE INSULATION			2014	7,395	361	20	361		2,936	13
14	HVAC REPAIRS			2016	6,257		3			4,432	14
15	HVAC REPAIRS			2017	5,519	1,073	3	1,073		5,043	15
16	20 TON ROOF AC UNIT			2017	21,855	2,186	10	2,186		7,285	16
17											17
18	HOME OFFICE DEPRECIATION					1,612		1,612			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

*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 Hamilton Memorial Rehab HCC # 0051292 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)		$ 586,628	$ 33,381		$ 33,381	$	$ 280,785	70

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

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	$ 12,812	$ 1,280	$ 1,280	$	Various	$ 6,813	71
72	Current Year Purchases	12,964	309	309		Various	309	72
73	Fully Depreciated Assets	118,405				Various	118,405	73
74								74
75	TOTALS	$ 144,181	$ 1,589	$ 1,589	$		$ 125,527	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Van	2011	$ 10,636	$	$	$	4	$ 10,636	76
77										77
78										78
79										79
80	TOTALS			$ 10,636	$	$	$		$ 10,636	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)	$ 769,945	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,970	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,970	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)	$ 416,948	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 Hamilton Memorial Rehab HCC # 0051292 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: $ 821 Description: Copier
(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 Hamilton Memorial Rehab HCC # 0051292 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		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	V39-03	hrs	$	1,450	$ 112,465	$	1,450	$ 112,465	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		560	43,894	428	560	44,322	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		1,171	86,503		1,171	86,503	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				23,010		23,010	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapy	V39-03			14	787		14	787	12
13	Other (specify): See WTB	V39-02,03				2,756	131,552		134,308	13
14	TOTAL			$	3,195	$ 246,405	$ 154,990	3,195	$ 401,395	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 Hamilton Memorial Rehab HCC # 0051292 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	$ 255,568	$ 263,470	1
2	Cash-Patient Deposits	51,991	51,991	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	195,031	195,031	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,715	67,715	6
7	Other Prepaid Expenses	127,269	127,269	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	251,415	251,415	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 948,989	$ 956,891	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		28,500	13
14	Buildings, at Historical Cost		399,000	14
15	Leasehold Improvements, at Historical Cost	187,627	187,627	15
16	Equipment, at Historical Cost	107,318	154,818	16
17	Accumulated Depreciation (book methods)	(229,283)	(416,948)	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):	45,962	45,962	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 111,624	$ 398,959	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,060,613	$ 1,355,850	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 339,800	$ 339,800	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,991	51,991	28
29	Short-Term Notes Payable	1,166,042	1,166,042	29
30	Accrued Salaries Payable	91,230	91,230	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,527	20,527	31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,957	12,957	32
33	Accrued Interest Payable			33
34	Deferred Compensation	478,007	478,007	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Management Fees Payable	429	429	36
37	Intercompany	27,909	27,909	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,188,892	$ 2,188,892	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,188,892	$ 2,188,892	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,128,279)	$ (833,042)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,060,613	$ 1,355,850	48

***(See instructions.)**

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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**	$ (897,360)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (897,360)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(230,919)	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)**	$ (230,919)	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)**	$ (1,128,279)	24 *

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

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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	$ 2,215,255	1
2	Discounts and Allowances for all Levels	(709,396)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,505,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,370,227	6
7	Oxygen	1,637	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,371,864	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	92	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	36,209	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,086	19
20	Radiology and X-Ray	719	20
21	Other Medical Services	6,144	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,250	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	303	28
28a	COVID-19 PHE Funding	251,415	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 251,718	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,173,721	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	619,817	31
32	Health Care	1,256,135	32
33	General Administration	741,534	33
	B. Capital Expense		
34	Ownership	224,169	34
	C. Ancillary Expense		
35	Special Cost Centers	446,860	35
36	Provider Participation Fee	116,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,404,640	40
41	**Income before Income Taxes (line 30 minus line 40)****	(230,919)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (230,919)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,556,945	44
45	Private Pay - Net Inpatient Revenue	602,073	45
46	Medicare - Net Inpatient Revenue	(657,134)	46
47	Other-(specify) Managed Care	(2,893)	47
48	Other-(specify) Hospice	6,868	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,505,859	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	1,618	1,754	$ 63,118	$ 35.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,164	9,874	286,396	29.01	3
4	Licensed Practical Nurses	9,814	10,494	245,921	23.43	4
5	CNAs & Orderlies	29,461	31,094	472,201	15.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,881	2,084	33,268	15.96	9
10	Activity Assistants	908	956	11,585	12.12	10
11	Social Service Workers	1,864	2,080	35,218	16.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,681	15,866	186,317	11.74	15
16	Dishwashers					16
17	Maintenance Workers	1,769	1,945	30,390	15.62	17
18	Housekeepers	7,396	7,764	85,264	10.98	18
19	Laundry	3,171	3,300	37,195	11.27	19
20	Administrator	1,868	2,080	81,388	39.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,818	4,168	64,829	15.55	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	559	559	7,903	14.14	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	941	1,112	20,395	18.34	33
34	TOTAL (lines 1 - 33)	88,913	95,130	$ 1,661,388 *	$ 17.46	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	$ 6,666	V01-3	35
36	Medical Director	Monthly	12,000	V09-3	36
37	Medical Records Consultant		646	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,614	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	3,550	V11-3	44
45	Social Service Consultant	Monthly	2,816	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,292		49

C. CONTRACT NURSES

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

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Boggess	Administrator	0	$ 81,388
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,388

B. Administrative - Other

Description	Amount
Tutera Health Care Services - Management Fees	$ 146,537
TOTAL (agree to Schedule V, line 17, col. 3)	$ 146,537
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Offices	Legal Services	$ 1,718
CliftonLarsonAllen LLP	Taxes/Cost Reports	8,978
Walnut Creek Management	Professional Service	629
Allscripts Healthcare LLC	Professional Service	4,850
Pinnacle Quality Insight	Professional Service	467
Property Valuation Services	Professional Service	100
Walnut Creek Management	Data Processing	31,857
Healthcare Information Systems	Data Processing	800
Providigm LLC	Data Processing	2,310
PointClickCare Technoligies Inc	Data Processing	19,272
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 70,981

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,845
Unemployment Compensation Insurance	
FICA Taxes	131,907
Employee Health Insurance	69,514
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	2,214
TOTAL (agree to Schedule V, line 22, col.8)	$ 223,480

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	$ 1,990
Advertising: Employee Recruitment	7,291
Health Care Worker Background Check	
(Indicate # of checks performed 36)	381
IL Health Care Association	4,104
ILHA PAC	288
Other Dues & Subscriptions	1,060
Other Licenses	576
Less: Public Relations Expense	(1,416)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,274

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	147
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 147

**See instructions.

Facility Name & ID Number Hamilton Memorial Rehab HCC # 0051292 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 $4,104**

(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. $ **16,974** 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. $ **116,125**
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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.