

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	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	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,158	5,120	2,240	17,518	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,158	5,120	2,240	17,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.99%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/17/2011

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 56 and days of care provided 2,004

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	175,956	17,129	341	193,426		193,426	193,426		1	
2	Food Purchase		80,208		80,208		80,208	(2,929)	77,279	2	
3	Housekeeping		13,745	71,531	85,276		85,276	85,276		3	
4	Laundry		7,401	45,484	52,885		52,885	52,885		4	
5	Heat and Other Utilities			119,400	119,400		119,400	1,140	120,540	5	
6	Maintenance	16,718	4,599	47,986	69,303		69,303	3,125	72,428	6	
7	Other (specify):*									7	
8	TOTAL General Services	192,674	123,082	284,742	600,498		600,498	1,336	601,834	8	
	B. Health Care and Programs										
9	Medical Director			2,000	2,000		2,000	2,000		9	
10	Nursing and Medical Records	851,314	66,050	4,441	921,805		921,805	33,774	955,579	10	
10a	Therapy									10a	
11	Activities	27,006	1,041	1,586	29,633		29,633	29,633		11	
12	Social Services	56,111		1,586	57,697		57,697	57,697		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*							3,486	3,486	15	
16	TOTAL Health Care and Programs	934,431	67,091	9,613	1,011,135		1,011,135	37,260	1,048,395	16	
	C. General Administration										
17	Administrative	65,574			65,574		65,574	1,780	67,354	17	
18	Directors Fees									18	
19	Professional Services			34,434	34,434	(2,863)	31,571	1,081	32,652	19	
20	Dues, Fees, Subscriptions & Promotions			37,893	37,893		37,893	(26,501)	11,392	20	
21	Clerical & General Office Expenses	33,321	16,641	39,653	89,615		89,615	50,818	140,433	21	
22	Employee Benefits & Payroll Taxes			300,090	300,090		300,090	300,090		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			2,943	2,943		2,943	1,591	4,534	24	
25	Other Admin. Staff Transportation			20,729	20,729		20,729	16,520	37,249	25	
26	Insurance-Prop.Liab.Malpractice			73,635	73,635		73,635	673	74,308	26	
27	Other (specify):*							17,338	17,338	27	
28	TOTAL General Administration	98,895	16,641	509,377	624,913	(2,863)	622,050	63,301	685,351	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,226,000	206,814	803,732	2,236,546	(2,863)	2,233,683	101,896	2,335,579	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Mem Nsg & Rehab Ctr

#0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,218	16,218		16,218	4,469	20,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,795	7,795		7,795	(7,795)	(0)			32
33	Real Estate Taxes			14,391	14,391	2,863	17,254	640	17,894			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)	(0)			34
35	Rent-Equipment & Vehicles			3,064	3,064		3,064	382	3,446			35
36	Other (specify):*											36
37	TOTAL Ownership			221,468	221,468	2,863	224,331	(182,305)	42,026			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,354	218,400	281,754		281,754		281,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,027	127,027		127,027		127,027			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		63,354	345,427	408,781		408,781		408,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,226,000	270,168	1,370,627	2,866,795		2,866,795	(80,409)	2,786,386			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,349)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,129)	30		9
10	Interest and Other Investment Income	(8,914)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(234)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,176)	21		18
19	Entertainment	(2,837)	21		19
20	Contributions	(2,850)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,509)	21		24
25	Fund Raising, Advertising and Promotional	(21,842)	20		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	(17,677)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (103,517)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	23,108		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 23,108		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (80,409)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Hamilton Mem Nsg & Rehab Ctr

ID# 0051292

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Machine Income	\$ (346)	02	1
2	Misc Income	(12,299)	21	2
3	Annual Report	(250)	20	3
4	Non Allowable Legal	(200)	19	4
5	Building Co Professional Fees	(1,786)	19	5
6	Non Allowable Seminar	(421)	24	6
7	Non Allowable Dues	(1,948)	20	7
8	Trust Fees	(427)	21	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	(17,677)	49

Hamilton Mem Nsg & Rehab Ctr

ID# 0051292

Report Period Beginning: 01/01/13

Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr# 0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2,929)											(2,929)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,140								1,140	5
6	Maintenance			2,284	841								3,125	6
7	Other (specify):*													7
8	TOTAL General Services	(2,929)		2,284	1,981								1,336	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			33,774									33,774	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,486									3,486	15
16	TOTAL Health Care and Programs			37,260									37,260	16
	C. General Administration													
17	Administrative			1,780									1,780	17
18	Directors Fees													18
19	Professional Services	(1,986)	1,786	1,258	23								1,081	19
20	Fees, Subscriptions & Promotions	(26,890)		389									(26,501)	20
21	Clerical & General Office Expenses	(42,248)		93,061	6								50,818	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(421)		2,012									1,591	24
25	Other Admin. Staff Transportation			16,520									16,520	25
26	Insurance-Prop.Liab.Malpractice			624	49								673	26
27	Other (specify):*			17,338									17,338	27
28	TOTAL General Administration	(71,545)	1,786	132,982	78								63,301	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,474)	1,786	172,525	2,059								101,896	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13 Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(20,129)	22,818	1,011	768								4,469	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,914)		191	928								(7,795)	32
33	Real Estate Taxes			64	575								640	33
34	Rent-Facility & Grounds		(180,000)	5,256	(5,256)								(180,000)	34
35	Rent-Equipment & Vehicles			382									382	35
36	Other (specify):*													36
37	TOTAL Ownership	(29,043)	(157,182)	6,904	(2,984)								(182,305)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(103,517)	(155,396)	179,429	(926)								(80,409)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6 Supp		See Pg 6 Supp		See Pg 6 Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Fees	\$	TI-McLeansboro LLC	100.00%	\$ 1,786	\$ 1,786	1
2	V	34 Rent	180,000	TI-McLeansboro LLC	100.00%		(180,000)	2
3	V	30 Depreciation		TI-McLeansboro LLC	100.00%	22,818	22,818	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			\$ 24,604	\$ * (155,396)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS, MAINTENANCE & SECUR	\$	Tutera Health Care Services	100.00%	\$ 2,284	\$ 2,284 15
16	V	10 NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	145	145 16
17	V	10 NURSING SALARIES		Tutera Health Care Services	100.00%	33,629	33,629 17
18	V	15 NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	3,486	3,486 18
19	V	17 OWNER SALARY- JOE TUTERA		Tutera Health Care Services	100.00%	1,780	1,780 19
20	V	19 PROFESSIONAL FEES	25	Tutera Health Care Services	100.00%	1,283	1,258 20
21	V	20 DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	389	389 21
22	V	21 OFFICE EXPENSES		Tutera Health Care Services	100.00%	8,054	8,054 22
23	V	21 OFFICE SALARIES		Tutera Health Care Services	100.00%	85,006	85,006 23
24	V	24 BUSINESS SEMINAR		Tutera Health Care Services	100.00%	2,012	2,012 24
25	V	25 TRAVEL EXPENSES		Tutera Health Care Services	100.00%	16,520	16,520 25
26	V	26 INSURANCE		Tutera Health Care Services	100.00%	624	624 26
27	V	27 EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	17,338	17,338 27
28	V	30 DEPRECIATION		Tutera Health Care Services	100.00%	1,011	1,011 28
29	V	32 INTEREST EXPENSE		Tutera Health Care Services	100.00%	191	191 29
30	V	33 REAL ESTATE TAXES		Tutera Health Care Services	100.00%	64	64 30
31	V	34 RENTAL OF SPACE		Tutera Health Care Services	100.00%	5,256	5,256 31
32	V	35 EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	74	74 32
33	V	35 AUTO RENTAL		Tutera Health Care Services	100.00%	308	308 33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 25			\$ 179,454	\$ * 179,429 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	Columbia 7611, LLC	100.00%	\$ 1,140	\$ 1,140
16	V	6 REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	841	841
17	V	19 PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	23	23
18	V	21 OFFICE EXPENSES		Columbia 7611, LLC	100.00%	6	6
19	V	26 INSURANCE		Columbia 7611, LLC	100.00%	49	49
20	V	30 DEPRECIATION		Columbia 7611, LLC	100.00%	768	768
21	V	32 INTEREST EXPENSE		Columbia 7611, LLC	100.00%	928	928
22	V	33 REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	575	575
23	V	34 RENT	5,256	Columbia 7611, LLC	100.00%		(5,256)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 5,256			\$ 4,330	\$ * (926)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Joseph Tutera	100%	Auburn Rehabilitation & Health Care Center	Auburn, IL	TI-Mcleansboro, LLC	Mcleansboro, IL	Building Company	1
2			Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Management Comp	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Services, LLC	Kansas City, MO	Management Co	3
4			Carlinville Rehabilitation & Health Care Center	Carlinville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Crystal Pines Rehabilitation & Health Care Center	Crystal Lake, IL	Walnut Creek- New England, LLC	Kansas City, MO	Management Co	5
6			Dixon Rehabilitation & Health Care Center	Dixon, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	6
7			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	The Atriums Senior Living Commu	Overland Park, KS	Independent/Assisted Living	7
8			Hamilton Memorial Rehabilitation & Health Care Center	McLeansboro, IL	Carnegie Village Senior Living Com	Belton, MO	Independent/Assisted Living	8
9			Highland Rehabilitation & Health Care Center	Kansas City, MO	Continua Home Health	Kansas/Missouri	Home Health	9
10			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Hospice KS	Kansas	Hospice	10
11			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice MO	Missouri	Hospice	11
12			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Country Gardens Assisted Living	Muskogee, OK	Assisted Living	12
13			Meridian Rehabilitation & Health Care Center	Wichita, KS	Gentilly Gardens Senior Living Co	Statesboro, GA	Assisted Living	13
14			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Lamar Court Assisted Living Com	Overland Park, KS	Assisted Living	14
15			Monterey Park Rehabilitation & Health Care Center	Independence, MO	Oakley Courts Assisted Living Com	Freeport, IL	Assisted Living	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Rose Estates Assisted Living Comm	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons Memory Care	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Living Commu	Kansas City, KS	Independent/Assisted Living	18
19			Charlton Place Rehabilitation & Health Care Center	Deatsville, AL	Wesley Court Assisted Living Com	Boiling Springs, SC	Assisted Living	19
20			Westridge Gardens Rehabilitation & Health Care Center	Raytown, MO	Willow Place Assisted Living & Me	Laurinburg, NC	Assisted Living	20
21			Willow Care Rehabilitation & Health Care Center	Hannibal, MO				21
22			Holly Hill House	Sulphur, LA				22
23			Rosewood Nursing Center	Lake Charles, LA				23
24			Beautiful Savior	Belton, MO				24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

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								1
2								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								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr # 0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Joseph Tutera	Owner	Administrative	100%	See Attached	1.22	2.03%	Alloc. Salary	\$ 1,780	17-7	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	\$ 1,780		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS, MAINTENANCE & S	PATIENT DAYS	704,115	24	\$ 91,797	\$ 17,519	\$ 2,284	1
2	10	NURSING & MEDICAL RECOR	PATIENT DAYS	704,115	24	5,822	17,519	145	2
3	10	NURSING SALARIES	PATIENT DAYS	704,115	24	1,351,593	1,351,593	33,629	3
4	15	NURSING TAXES & BENEFITS	PATIENT DAYS	704,115	24	140,104	17,519	3,486	4
5	17	OWNER SALARY- JOE TUTER	PATIENT DAYS	704,115	24	71,528	71,528	1,780	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	704,115	24	51,570	17,519	1,283	6
7	20	DUES, FEES, LICENSES, MEM	PATIENT DAYS	704,115	24	15,649	17,519	389	7
8	21	OFFICE EXPENSES	PATIENT DAYS	704,115	24	323,707	17,519	8,054	8
9	21	OFFICE SALARIES	PATIENT DAYS	704,115	24	3,416,537	3,416,537	85,006	9
10	24	BUSINESS SEMINAR	PATIENT DAYS	704,115	24	80,864	17,519	2,012	10
11	25	TRAVEL EXPENSES	PATIENT DAYS	704,115	24	663,971	17,519	16,520	11
12	26	INSURANCE	PATIENT DAYS	704,115	24	25,084	17,519	624	12
13	27	EMP BENEFITS & PAYROLL T	PATIENT DAYS	704,115	24	696,836	17,519	17,338	13
14	30	DEPRECIATION	PATIENT DAYS	704,115	24	40,633	17,519	1,011	14
15	32	INTEREST EXPENSE	PATIENT DAYS	704,115	24	7,671	17,519	191	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	704,115	24	2,590	17,519	64	16
17	34	RENTAL OF SPACE	PATIENT DAYS	704,115	24	211,243	17,519	5,256	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	704,115	24	2,964	17,519	74	18
19	35	AUTO RENTAL	PATIENT DAYS	704,115	24	12,377	17,519	308	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,212,541	\$ 4,839,657		\$ 179,454	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Columbia 7611, LLC
 Street Address 7611 State Line Road
 City / State / Zip Code Kansas City, Missouri 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-0081

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	704,115	24	\$ 45,827	\$ 17,519	\$ 1,140	1
2	6	REPAIRS, MAINTENANCE & S	PATIENT DAYS	704,115	24	33,791	17,519	841	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	704,115	24	925	17,519	23	3
4	21	OFFICE EXPENSES	PATIENT DAYS	704,115	24	225	17,519	6	4
5	26	INSURANCE	PATIENT DAYS	704,115	24	1,976	17,519	49	5
6	30	DEPRECIATION	PATIENT DAYS	704,115	24	30,872	17,519	768	6
7	32	INTEREST EXPENSE	PATIENT DAYS	704,115	24	37,300	17,519	928	7
8	33	REAL ESTATE TAXES	PATIENT DAYS	704,115	24	23,127	17,519	575	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					\$ 174,043	\$	\$ 4,330	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	Note Payable		X					1,068,799			7,454	6				
7												7				
8												8				
9	TOTAL Facility Related															
	B. Non-Facility Related*															
10	Interest Income										(8,914)	10				
11	Additional Interest Expense										341	11				
12	Allocated from Tintera Health Care Services										191	12				
13	See Supplemental Schedule										928	13				
14	TOTAL Non-Facility Related															
15	TOTALS (line 9+line14)															

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

** 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 Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
6												6					
7	TOTAL Long-Term											7					
	Working Capital																
8							\$	\$			\$	8					
9												9					
10												10					
11												11					
12												12					
13												13					
14	TOTAL Working Capital											14					
	B. Non-Facility Related*																
15	Allocated from Columbia 7611, LLC						\$	\$			\$ 928	15					
16												16					
17												17					
18												18					
19												19					
20	TOTAL Non-Facility Related										928	20					

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>26,251</u>	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.)		\$	<u>15,031</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(11,220)</u>	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>26,251</u>	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.)		\$	<u>2,863</u>	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.		\$	<u>17,894</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>13,824</u>	8	FOR BHF USE ONLY	
	2009	<u>17,581</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2010	<u>17,834</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	<u>14,399</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2012	<u>14,391</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>Beginning Accrual Adj</u>					
<u>Allocated from Tutera Health Care Services- \$64</u>					
<u>Allocated from Columbia 7611, LLC- \$575</u>					

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hamilton Mem Nsg & Rehab Ctr COUNTY Hamilton
 FACILITY IDPH LICENSE NUMBER 0051292
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-030-005-25</u>	<u>Long Term Care Property</u>	\$ <u>14,391.38</u>	\$ <u>14,391.38</u>
2. <u>47-920-06-15-02-0-00-000</u>	<u>Allocated from Management</u>	\$ <u>69,694.64</u>	\$ <u>575.41</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>84,086.02</u></u>	\$ <u><u>14,966.79</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,923 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2011</u>	<u>\$ 28,500</u>	<u>1</u>
2	<u>Allocated from Columbia 7611, LLC</u>			<u>2,353</u>	<u>2</u>
3	TOTALS			\$ 30,853	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		2011	1970	\$ 399,000	\$ 14,509	39	\$ 10,231	\$ (4,278)	\$ 30,692	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			25,462	850	828	(22)	17,775	68
69				7,442		(7,442)		69
70			\$ 424,462	\$ 22,801		\$ 11,059	\$ (11,742)	\$ 48,467 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12A, Carried Forward		\$ 424,462	\$ 22,801		\$ 11,059	\$ (11,742)	\$ 48,467	1
2	Laundry(Drywall,Door,Paint,Locks,Fan,Light Fixture,Floor Repair)	2011	8,600		20	430	430	2,720	2
3	Pcc Equipment	2012	5,905		20	295	295	14,742	3
4	Breezeway Renovation (Windows)	2012	10,460		20	523	523	5,956	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
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18									18
19									19
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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	TOTAL (lines 1 thru 33)		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hamilton Mem Nsg & Rehab Ctr**

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward								
2		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886		
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
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24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34	TOTAL (lines 1 thru 33)		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
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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	TOTAL (lines 1 thru 33)		\$ 449,427	\$ 22,801		\$ 12,307	\$ (10,494)	\$ 71,886	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	<u>Allocated from Columbia 7611, LLC</u>	<u>1989</u>	<u>20,345</u>	<u>645</u>	<u>35</u>	<u>581</u>	<u>(64)</u>	<u>14,532</u>	3
4	<u>Allocated from Columbia 7611, LLC</u>	<u>1990</u>	<u>2,328</u>	<u>74</u>	<u>35</u>	<u>67</u>	<u>(7)</u>	<u>1,596</u>	4
5	<u>Allocated from Columbia 7611, LLC</u>	<u>1991</u>	<u>308</u>	<u>10</u>	<u>35</u>	<u>9</u>	<u>(1)</u>	<u>202</u>	5
6									6
7									7
8	Leasehold Information								8
9	<u>Allocated from Walnut Creek Management Company</u>	<u>2006</u>	<u>1,034</u>	<u>78</u>	<u>20</u>	<u>52</u>	<u>(26)</u>	<u>414</u>	9
10	<u>Allocated from Walnut Creek Management Company</u>	<u>2007</u>	<u>25</u>	<u>4</u>	<u>20</u>	<u>49</u>	<u>45</u>	<u>345</u>	10
11	<u>Allocated from LTC Services, LLC</u>	<u>2001</u>	<u>42</u>		<u>20</u>	<u>2</u>	<u>2</u>	<u>27</u>	11
12	<u>Allocated from LTC Services, LLC</u>	<u>2002</u>	<u>39</u>		<u>20</u>	<u>2</u>	<u>2</u>	<u>23</u>	12
13	<u>Allocated from Columbia 7611, LLC</u>	<u>1989</u>	<u>11</u>		<u>20</u>			<u>11</u>	13
14	<u>Allocated from Columbia 7611, LLC</u>	<u>1994</u>	<u>58</u>	<u>1</u>	<u>20</u>	<u>3</u>	<u>2</u>	<u>58</u>	14
15	<u>Allocated from Columbia 7611, LLC</u>	<u>1995</u>	<u>90</u>	<u>2</u>	<u>20</u>	<u>4</u>	<u>2</u>	<u>85</u>	15
16	<u>Allocated from Columbia 7611, LLC</u>	<u>1996</u>	<u>167</u>	<u>2</u>	<u>20</u>	<u>8</u>	<u>6</u>	<u>150</u>	16
17	<u>Allocated from Columbia 7611, LLC</u>	<u>2003</u>	<u>65</u>	<u>2</u>	<u>20</u>	<u>3</u>	<u>1</u>	<u>36</u>	17
18	<u>Allocated from Columbia 7611, LLC</u>	<u>2006</u>	<u>315</u>	<u>14</u>	<u>20</u>	<u>16</u>	<u>2</u>	<u>126</u>	18
19	<u>Allocated from Columbia 7611, LLC</u>	<u>2008</u>	<u>497</u>	<u>14</u>	<u>20</u>	<u>25</u>	<u>11</u>	<u>149</u>	19
20	<u>Allocated from Columbia 7611, LLC</u>	<u>2011</u>	<u>138</u>	<u>4</u>	<u>20</u>	<u>7</u>	<u>3</u>	<u>21</u>	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$	\$		\$	\$	\$	\$	1
2									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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 25,462	\$ 850		\$ 828	\$ (22)	\$ 17,775	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 57,051	\$ 17,475	\$ 5,705	\$ (11,770)	10	\$ 32,652	71
72	Current Year Purchases	312	245	31	(214)	10	31	72
73	Fully Depreciated Assets	6,315		113	113	10	6,315	73
74								74
75	TOTALS	\$ 63,678	\$ 17,720	\$ 5,849	\$ (11,871)		\$ 38,998	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		Van	2011	\$ 10,636	\$	\$ 2,127	\$ 2,127	5	\$ 9,328	76
77		Allocated from Walnut Creek M		2,627	295	404	109	5	2,257	77
78		Allocated from LTC Services, LL		978				5	978	78
79										79
80	TOTALS			\$ 14,241	\$ 295	\$ 2,531	\$ 2,236		\$ 12,563	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)	\$ 558,199	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,816	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,687	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,129)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 123,447	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 3,138 Description: See Attached Schedule

(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	<u>Allocated from Tutura Health Care Services</u>		\$	\$ <u>308</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>308</u>	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.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8	
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	82,724	\$			\$	82,724	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				18,475					18,475	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				109,597		134			109,731	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescrpts						48,225			48,225	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>See Supplemental</u>						7,604		14,995			22,599	13
14	TOTAL			\$		\$	218,400	\$	63,354	\$		281,754	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,696	\$ 79,614	1
2	Cash-Patient Deposits	14,279	14,279	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	519,145	519,145	3
4	Supply Inventory (priced at)	10,925	10,925	4
5	Short-Term Investments			5
6	Prepaid Insurance	26,540	26,540	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	37,624	37,624	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 612,209	\$ 688,127	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	129,428	129,428	15
16	Equipment, at Historical Cost	88,177	135,677	16
17	Accumulated Depreciation (book methods)	(74,348)	(139,165)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 143,257	\$ 553,440	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 755,466	\$ 1,241,567	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 116,356	\$ 116,356	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,279	14,279	28
29	Short-Term Notes Payable	1,068,799	1,068,799	29
30	Accrued Salaries Payable	109,141	109,141	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,801	11,801	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,251	26,251	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,346,627	\$ 1,346,627	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	<u>See Attached Schedule</u>	27,900	27,900	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,900	\$ 27,900	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,374,527	\$ 1,374,527	46
47	TOTAL EQUITY(page 18, line 24)	\$ (619,061)	\$ (132,960)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 755,466	\$ 1,241,567	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (417,039)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (417,041)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(202,020)	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)	\$ (202,020)	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)	\$ (619,061)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,984,060	1
2	Discounts and Allowances for all Levels	44,574	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,028,634	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	475,870	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 475,870	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	2,349	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,079	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,470	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,259	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 133,157	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,469	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,469	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	12,645	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,645	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,664,775	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	600,498	31
32	Health Care	1,011,135	32
33	General Administration	624,913	33
B. Capital Expense			
34	Ownership	221,468	34
C. Ancillary Expense			
35	Special Cost Centers	281,754	35
36	Provider Participation Fee	127,027	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,866,795	40
41	Income before Income Taxes (line 30 minus line 40)**	(202,020)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (202,020)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,132,781	44
45	Private Pay - Net Inpatient Revenue	570,708	45
46	Medicare - Net Inpatient Revenue	325,145	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,028,634	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	4,943	5,476	\$ 121,293	\$ 22.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,050	9,278	171,858	18.52	3
4	Licensed Practical Nurses	10,604	11,312	202,425	17.89	4
5	CNAs & Orderlies	34,756	36,401	355,603	9.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,557	2,770	27,006	9.75	10
11	Social Service Workers	3,614	4,000	56,111	14.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,454	16,515	175,956	10.65	15
16	Dishwashers					16
17	Maintenance Workers	710	775	16,718	21.57	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	65,574	31.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,572	2,572	33,321	12.96	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	8	9	135	15.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	86,348	91,188	\$ 1,226,000 *	\$ 13.44	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 341	01-03	35
36	Medical Director	Monthly	2,000	09-03	36
37	Medical Records Consultant	Monthly	1,544	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,897	10-03	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	1,586	11-03	44
45	Social Service Consultant	Monthly	1,586	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,954		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Kelly C Boggess	Administrator	0.00%	\$ 65,574	Workers' Compensation Insurance	\$ 80,900	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	6,507		
				FICA Taxes	93,789	Health Care Worker Background Check	287		
				Employee Health Insurance	107,140	(Indicate # of checks performed <u>28</u>)			
				Employee Meals		Patient Background Checks	61		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,506		
				Other Employee Benefits	18,262	Licenses	103		
						Allocated from Tutera Health Care Services	389		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,574						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				Less: Public Relations Expense ()		
			\$				Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Daniel Maher Law Office	Legal- adj pg 5a	\$ 200					Out-of-State Travel	\$	
Thomas & Thorngren	Unemployment Consulting	540							
Traphagen Financial Group	Accounting	7,366							
E-Health Data	Data Processing	11,578					In-State Travel		
Emdeon Business Services	Data Processing	846							
Galaxy Hosted Software	Data Processing	500							
Tutera Health Care Services	Accounting	25							
Healthcare Information Systems	Data Processing	550					Seminar Expense	2,522	
Pinnacle Quality Insight	Customer Satisfaction Survey	1,239					Allocated from Tutera Health Care Services	2,012	
Wescom Solutions	Data Processing	8,716							
Property Valuation Services	Property Valuation	2,863							
See Supplemental Schedule		11					Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 34,433	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,534

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hamilton Mem Nsg & Rehab Ctr

0051292

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 Healthcare Association \$3,312
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,010 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 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. \$ 127,027
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,349
- (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% ln 14
 - 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? No
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.