FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0049239

Facility Name: Carlinville Rehab & HCC

Address: 751 North Oak Street (Number) Carlinville (City) 62626 (Zip Code)

County: Macoupin

Telephone Number: (217) 854-2511 **Fax #** (217) 854-4377

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Steven N. Lavenda, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	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	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,837	4,244	3,638	25,719	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,837	4,244	3,638	25,719	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.90%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 02/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 2,481

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		3,665	308,691	312,356		312,356	(562)	311,794			1
2	Food Purchase		8,353		8,353		8,353	(1,032)	7,321			2
3	Housekeeping		9,995	105,575	115,570		115,570		115,570			3
4	Laundry		7,366	65,058	72,424		72,424		72,424			4
5	Heat and Other Utilities			84,378	84,378		84,378	908	85,286			5
6	Maintenance	32,637	4,299	72,308	109,244		109,244	1,032	110,276			6
7	Other (specify):*											7
8	TOTAL General Services	32,637	33,678	636,010	702,325		702,325	346	702,671			8
	B. Health Care and Programs											
9	Medical Director			18,160	18,160		18,160		18,160			9
10	Nursing and Medical Records	1,374,194	140,563	4,855	1,519,612		1,519,612	25,182	1,544,794			10
10a	Therapy											10a
11	Activities	43,840	10,684	2,759	57,283		57,283		57,283			11
12	Social Services	65,952		4,630	70,582		70,582		70,582			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,393	6,393			15
16	TOTAL Health Care and Programs	1,483,986	151,247	30,404	1,665,637		1,665,637	31,575	1,697,212			16
	C. General Administration											
17	Administrative	66,974			66,974		66,974		66,974			17
18	Directors Fees											18
19	Professional Services			63,263	63,263	(100)	63,163	(7,424)	55,739			19
20	Dues, Fees, Subscriptions & Promotions			77,234	77,234		77,234	(30,379)	46,855			20
21	Clerical & General Office Expenses	73,962	19,965	261,116	355,043		355,043	(128,295)	226,748			21
22	Employee Benefits & Payroll Taxes			242,759	242,759		242,759		242,759			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,671	4,671		4,671	1,395	6,066			24
25	Other Admin. Staff Transportation			14,849	14,849		14,849	17,262	32,111			25
26	Insurance-Prop.Liab.Malpractice			95,718	95,718		95,718	1,243	96,961			26
27	Other (specify):*							19,605	19,605			27
28	TOTAL General Administration	140,936	19,965	759,610	920,511	(100)	920,411	(126,592)	793,819			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,657,559	204,890	1,426,024	3,288,473	(100)	3,288,373	(94,671)	3,193,702			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Carlinville Rehab & HCC #0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,926	11,926		11,926	94,428	106,354			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,719	5,719		5,719	71,337	77,056			32
33	Real Estate Taxes			48,000	48,000	100	48,100	779	48,879			33
34	Rent-Facility & Grounds			207,140	207,140		207,140	(206,418)	722			34
35	Rent-Equipment & Vehicles			12,463	12,463		12,463	3,378	15,841			35
36	Other (specify):*							14,816	14,816			36
37	**TOTAL Ownership**			285,248	285,248	100	285,348	(21,679)	263,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		199,442	453,690	653,132		653,132		653,132			39
40	Barber and Beauty Shops			200	200		200		200			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,924	194,924		194,924		194,924			42
43	Other (specify):*			68	68		68	(68)	0			43
44	**TOTAL Special Cost Centers**		199,442	648,882	848,324		848,324	(68)	848,256			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,657,559	404,332	2,360,154	4,422,045		4,422,045	(116,418)	4,305,627			45

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,103)	30		9
10	Interest and Other Investment Income	(5,851)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	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	(3,630)	21		18
19	Entertainment	(12,363)	21		19
20	Contributions	(500)	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	(219,098)	21		24
25	Fund Raising, Advertising and Promotional	(28,886)	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	(25,670)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (303,115)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	186,697		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 186,697		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (116,418)		37

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

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

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

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Carlinville Rehab & HCC

ID# **0049239**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Taxes	$ (37)	21	1
2	Miscellaneous Income	(161)	21	2
3	Prior Year Medical Services	(532)	10	3
4	Prior Year R&M	(395)	06	4
5	Prior Year Dietary Consultant	(562)	01	5
6	Prior Year Marketing Expenses	(68)	43	6
7	PAC Dues	(1,731)	20	7
8	Building Company - Legal Fees	(450)	19	8
9	Building Company - Accounting	(9,999)	19	9
10	Building Company - Bank Service Charges	(37)	21	10
11	Building Company - Amortization	(1,750)	36	11
12	Non-Allowable Legal	(7,603)	19	12
13	Non-Allowable Seminars	(1,328)	24	13
14	Meals	(1,018)	02	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**	(25,670)		49

Carlinville Rehab & HCC

ID# 0049239

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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 Carlinville Rehab & HCC **#** 0049239 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(562)											(562)	1
2	Food Purchase	(1,032)											(1,032)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				908								908	5
6	Maintenance	(395)		540	887								1,032	6
7	Other (specify):*													7
8	**TOTAL General Services**	(1,989)		540	1,795								346	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(532)		25,714									25,182	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,393									6,393	15
16	**TOTAL Health Care and Programs**	(532)		32,107									31,575	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(18,052)	10,449	107	73								(7,424)	19
20	Fees, Subscriptions & Promotions	(31,117)		738									(30,379)	20
21	Clerical & General Office Expenses	(235,326)	37	106,989	5								(128,295)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,328)		2,723									1,395	24
25	Other Admin. Staff Transportation			17,262									17,262	25
26	Insurance-Prop.Liab.Malpractice			1,182	61								1,243	26
27	Other (specify):*			19,605									19,605	27
28	**TOTAL General Administration**	(285,822)	10,486	148,607	138								(126,592)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(288,343)	10,486	181,254	1,933								(94,671)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlinville Rehab & HCC **#** 0049239 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,103)	95,919	4,375	1,237								94,428	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,851)	77,051		137								71,337	32
33	Real Estate Taxes			58	721								779	33
34	Rent-Facility & Grounds		(206,418)	6,191	(6,191)								(206,418)	34
35	Rent-Equipment & Vehicles			3,378									3,378	35
36	Other (specify):*	(1,750)	16,566										14,816	36
37	TOTAL Ownership	(14,704)	(16,882)	14,002	(4,095)								(21,679)	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):*	(68)											(68)	43
44	TOTAL Special Cost Centers	(68)											(68)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(303,115)	(6,396)	195,256	(2,162)								(116,418)	45

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 206,418	TI - Carlinville	100.00%	$	$ (206,418)	1
2	V	32	Interest	155	TI - Carlinville	100.00%	77,206	77,051	2
3	V	19	Legal		TI - Carlinville	100.00%	450	450	3
4	V	19	Accounting		TI - Carlinville	100.00%	9,999	9,999	4
5	V	21	Bank Service Charges		TI - Carlinville	100.00%	37	37	5
6	V	36	MIP Expense		TI - Carlinville	100.00%	14,816	14,816	6
7	V	30	Depreciation		TI - Carlinville	100.00%	95,919	95,919	7
8	V	36	Amortization		TI - Carlinville	100.00%	1,750	1,750	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 206,573			$ 200,177	$ * (6,396)	14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS, MAINTENANCE & SECUR	$	Tutera Health Care Services	100.00%	$ 540	$ 540	15
16	V	10	NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	141	141	16
17	V	10	NURSING SALARIES		Tutera Health Care Services	100.00%	25,573	25,573	17
18	V	15	NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	6,393	6,393	18
19	V	19	PROFESSIONAL FEES		Tutera Health Care Services	100.00%	107	107	19
20	V	20	DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	738	738	20
21	V	21	OFFICE EXPENSES		Tutera Health Care Services	100.00%	9,975	9,975	21
22	V	21	OFFICE SALARIES		Tutera Health Care Services	100.00%	97,014	97,014	22
23	V	24	BUSINESS SEMINAR		Tutera Health Care Services	100.00%	2,723	2,723	23
24	V	25	TRAVEL EXPENSES		Tutera Health Care Services	100.00%	17,262	17,262	24
25	V	26	INSURANCE		Tutera Health Care Services	100.00%	1,182	1,182	25
26	V	27	EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	19,605	19,605	26
27	V	30	DEPRECIATION		Tutera Health Care Services	100.00%	4,375	4,375	27
28	V	32	INTEREST EXPENSE		Tutera Health Care Services	100.00%			28
29	V	33	REAL ESTATE TAXES		Tutera Health Care Services	100.00%	58	58	29
30	V	34	RENTAL OF SPACE		Tutera Health Care Services	100.00%	6,191	6,191	30
31	V	35	EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	506	506	31
32	V	35	AUTO RENTAL		Tutera Health Care Services	100.00%	2,872	2,872	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 195,256	$ * 195,256	39

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	Columbia 7611, LLC	100.00%	$ 908	$ 908	15
16	V	6	REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	887	887	16
17	V	19	PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	73	73	17
18	V	21	OFFICE EXPENSES		Columbia 7611, LLC	100.00%	5	5	18
19	V	26	INSURANCE		Columbia 7611, LLC	100.00%	61	61	19
20	V	30	DEPRECIATION		Columbia 7611, LLC	100.00%	1,237	1,237	20
21	V	32	INTEREST EXPENSE		Columbia 7611, LLC	100.00%	137	137	21
22	V	33	REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	721	721	22
23	V								23
24	V	34	RENT	6,191	Columbia 7611, LLC	100.00%		(6,191)	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			$ 6,191			$ 4,029	$ * (2,162)	39

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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.**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE	160,764,752	31	$ 20,697	$	4,195,369	$ 540	1
2	10	NURSING & MEDICAL RECOR	OPERATING EXPENSE	160,764,752	31	5,416		4,195,369	141	2
3	10	NURSING SALARIES	OPERATING EXPENSE	160,764,752	31	979,937	979,937	4,195,369	25,573	3
4	15	NURSING TAXES & BENEFITS	OPERATING EXPENSE	160,764,752	31	244,977		4,195,369	6,393	4
5	19	PROFESSIONAL FEES	OPERATING EXPENSE	160,764,752	31	4,102		4,195,369	107	5
6	20	DUES, FEES, LICENSES, MEMI	OPERATING EXPENSE	160,764,752	31	28,269		4,195,369	738	6
7	21	OFFICE EXPENSES	OPERATING EXPENSE	160,764,752	31	382,252		4,195,369	9,975	7
8	21	OFFICE SALARIES	OPERATING EXPENSE	160,764,752	31	3,717,531	3,717,531	4,195,369	97,014	8
9	24	BUSINESS SEMINAR	OPERATING EXPENSE	160,764,752	31	104,327		4,195,369	2,723	9
10	25	TRAVEL EXPENSES	OPERATING EXPENSE	160,764,752	31	661,487		4,195,369	17,262	10
11	26	INSURANCE	OPERATING EXPENSE	160,764,752	31	45,302		4,195,369	1,182	11
12	27	EMP BENEFITS & PAYROLL T	OPERATING EXPENSE	160,764,752	31	751,270		4,195,369	19,605	12
13	30	DEPRECIATION	OPERATING EXPENSE	160,764,752	31	167,643		4,195,369	4,375	13
14	32	INTEREST EXPENSE	OPERATING EXPENSE	160,764,752	31			4,195,369		14
15	33	REAL ESTATE TAXES	OPERATING EXPENSE	160,764,752	31	2,226		4,195,369	58	15
16	34	RENTAL OF SPACE	OPERATING EXPENSE	160,764,752	31	237,236		4,195,369	6,191	16
17	35	EQUIPMENT RENTAL	OPERATING EXPENSE	160,764,752	31	19,392		4,195,369	506	17
18	35	AUTO RENTAL	OPERATING EXPENSE	160,764,752	31	110,058		4,195,369	2,872	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,482,120	$ 4,697,468		$ 195,256	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	OPERATING EXPENSE	160,764,752	31	$ 34,777	$	4,195,369	$ 908	1
2	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE	160,764,752	31	33,996		4,195,369	887	2
3	19	PROFESSIONAL FEES	OPERATING EXPENSE	160,764,752	31	2,779		4,195,369	73	3
4	21	OFFICE EXPENSES	OPERATING EXPENSE	160,764,752	31	182		4,195,369	5	4
5	26	INSURANCE	OPERATING EXPENSE	160,764,752	31	2,337		4,195,369	61	5
6	30	DEPRECIATION	OPERATING EXPENSE	160,764,752	31	47,396		4,195,369	1,237	6
7	32	INTEREST EXPENSE	OPERATING EXPENSE	160,764,752	31	5,268		4,195,369	137	7
8	33	REAL ESTATE TAXES	OPERATING EXPENSE	160,764,752	31	27,638		4,195,369	721	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					$ 154,373	$		$ 4,029	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Tutera Investments		X	Note Payable			$	$ 638,718			$ 5,719	1
2	TI - Carlinville LLC		X	Mortgage Payable				2,936,483			77,206	2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Columbia 7611 LLC		X								137	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,575,200			$ 83,061	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,851)	10
11	Interest Income - Bldg Co.		X								(155)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,005)	14
15	TOTALS (line 9+line14)						$	$ 3,575,200			$ 77,056	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 14,816 Line # 36

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

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												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							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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.)

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 38,313	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.)		$ 39,500	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,187	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 47,592	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.)**		$ 100	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.		$ 48,879	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	42,331	8
	2010	39,368	9
	2011	37,473	10
	2012	38,313	11
	2013	38,721	12

2014 Accrual: $38,721 x 1.23 = $47,592 (Rounded)

Allocated from Tutera HC Services: $58

Allocated from Columbia 7611 LLC: $721

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlinville Rehab & HCC COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0049239

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-002-056-00	Long Term Care Property	$ 38,721.10	$ 38,721.10
2.	47-920-06-15-02-0-00-000	Home Office Allocation	$ 69,638.00	$ 721.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,359.10	$ 39,442.34

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlinville Rehab & HCC COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0049239

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 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,500 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		2008	$ 192,000	1
2	Allocated from Columbia 7611 LLC			2,952	2
3	TOTALS			$ 194,952	3

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2008	1975	$ 2,688,967	$ 59,345	35	$ 56,229	$ (3,116)	$ 527,209	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	4,300		20	215	215	2,078	9
10	Various			2010	23,043		20	1,152	1,152	7,233	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		329,401			16,470	16,470	32,940	67
68	Related Party Allocations (Pages 12H & 12I)		32,352	1,513		994	(519)	22,785	68
69	Financial Statement Depreciation			11,926			(11,926)		69
70	TOTAL (lines 4 thru 69)		$ 3,078,063	$ 72,784		$ 75,060	$ 2,276	$ 592,245	70

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,078,063	$ 72,784		$ 75,060	$ 2,276	$ 592,245	1
2	Backflow Preventor	2012	6,590		20	330	330	4,119	2
3	Wireless Infrastructure & Wiring	2012	19,293		20	965	965	1,929	3
4	Building Renovations -Part 2	2013	5,538		20	277	277	554	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12B, Carried Forward		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12C, Carried Forward		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	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
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21									21
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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)		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12D, Carried Forward		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	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 (lines 1 thru 33)		$ 3,109,483	$ 72,784		$ 76,631	$ 3,847	$ 598,847	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Building Renovations - Hallways, Resident Rooms, Dining Hall	2013	329,401		20	16,470	16,470	32,940	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)		$ 329,401	$		$ 16,470	$ 16,470	$ 32,940	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 329,401	$		$ 16,470	$ 16,470	$ 32,940	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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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)		$ 329,401	$		$ 16,470	$ 16,470	$ 32,940	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Columbia 7611 LLC	1989	25,522	995	35	729	(266)	18,959	3
4	Allocated from Columbia 7611 LLC	1990	2,920	107	35	83	(24)	2,086	4
5	Allocated from Columbia 7611 LLC	1991	386	14	35	11	(3)	265	5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Walnut Creek Management	2006	1,106		20	55	55	498	9
10	Allocated from Walnut Creek Management	2007	26	1	20	1		11	10
11	Allocated from Walnut Creek Management	2014	625	360	20	31	(329)	31	11
12									12
13	Allocated from LTC Services LLC	2001	45		20	2	2	31	13
14	Allocated from LTC Services LLC	2002	42		20	2	2	27	14
15									15
16	Allocated from Columbia 7611 LLC	1989	14					14	16
17	Allocated from Columbia 7611 LLC	1994	72	2	20		(2)	72	17
18	Allocated from Columbia 7611 LLC	1995	112	3	20	6	3	112	18
19	Allocated from Columbia 7611 LLC	1996	209	4	20	10	6	199	19
20	Allocated from Columbia 7611 LLC	2003	81	2	20	4	2	49	20
21	Allocated from Columbia 7611 LLC	2006	395		20	20	20	178	21
22	Allocated from Columbia 7611 LLC	2008	624	20	20	31	11	218	22
23	Allocated from Columbia 7611 LLC	2011	173	5	20	9	4	35	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)		$ 32,352	$ 1,513		$ 994	$ (519)	$ 22,785	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 32,352	$ 1,513		$ 994	$ (519)	$ 22,785	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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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)		$ 32,352	$ 1,513		$ 994	$ (519)	$ 22,785	34

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 304,609	$ 39,699	$ 29,266	$ (10,433)	10	$ 161,677	71
72	Current Year Purchases	1,111	745	111	(634)	10	111	72
73	Fully Depreciated Assets	7,692	85	214	129	10	7,692	73
74								74
75	TOTALS	$ 313,412	$ 40,529	$ 29,591	$ (10,938)		$ 169,480	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		Allocated from Walnut Creek Ma	2014	$ 2,811	$ 144	$ 132	$ (12)	5	$ 2,547	76
77		Allocated from LTC Services LL	2014	1,047				5	1,047	77
78										78
79										79
80	TOTALS			$ 3,858	$ 144	$ 132	$ (12)		$ 3,594	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,621,705	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,457	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,354	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,103)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 771,921	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Storage				722			5
6								6
7	TOTAL				$ 722 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 12,969 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	Allocated from Tutera HC Services		$	$ 2,872	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,872	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 160,106	$ 35		$ 160,141	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			80,544	46		80,590	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			170,103	506		170,609	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				110,378		110,378	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					42,937	88,477		131,414	13
14	TOTAL			$		$ 453,690	$ 199,442		$ 653,132	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.

STATE OF ILLINOIS

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 644,023	$ 654,797	1
2	Cash-Patient Deposits	20,559	20,559	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	804,470	804,470	3
4	Supply Inventory (priced at)	14,272	14,272	4
5	Short-Term Investments			5
6	Prepaid Insurance	213,001	220,481	6
7	Other Prepaid Expenses	75,029	75,029	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	23,088	23,088	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,794,442	$ 1,812,696	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		192,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	37,003	2,351,470	15
16	Equipment, at Historical Cost	52,672	304,112	16
17	Accumulated Depreciation (book methods)	(85,806)	(687,826)	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):	7,783	271,497	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,652	$ 2,431,253	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,806,094	$ 4,243,949	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 489,813	$ 489,813	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,559	20,559	28
29	Short-Term Notes Payable	638,718	638,718	29
30	Accrued Salaries Payable	71,422	71,422	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,373	28,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,313	47,592	32
33	Accrued Interest Payable		6,362	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)**	$ 1,287,198	$ 1,302,839	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,936,483	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	75	75	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 75	$ 2,936,558	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,287,273	$ 4,239,397	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 518,821	$ 4,552	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,806,094	$ 4,243,949	48

***(See instructions.)**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 366,277	1	
2	Restatements (describe):		2	
3	**Equity Restatement**	829,558	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,195,835	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	143,499	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	(820,513)	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)**	$ (677,014)	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)**	$ 518,821	24	*

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,431,324	1
2	Discounts and Allowances for all Levels	(84,273)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,347,051	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	895,357	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 895,357	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	262,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,225	19
20	Radiology and X-Ray		20
21	Other Medical Services	45,291	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 317,124	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,851	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,851	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	161	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 161	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,565,544	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	702,325	31
32	Health Care	1,665,637	32
33	General Administration	920,511	33
	B. Capital Expense		
34	Ownership	285,248	34
	C. Ancillary Expense		
35	Special Cost Centers	653,400	35
36	Provider Participation Fee	194,924	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,422,045	40
41	**Income before Income Taxes (line 30 minus line 40)****	143,499	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 143,499	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,310,842	44
45	Private Pay - Net Inpatient Revenue	641,308	45
46	Medicare - Net Inpatient Revenue	325,084	46
47	Other-(specify)	69,817	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,347,051	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.**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,076	7,480	$ 193,233	$ 25.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,932	8,177	196,902	24.08	3
4	Licensed Practical Nurses	18,558	19,617	378,878	19.31	4
5	CNAs & Orderlies	55,324	57,275	587,691	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,607	3,839	43,840	11.42	10
11	Social Service Workers	3,883	4,102	65,952	16.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,715	1,971	32,637	16.56	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,952	2,132	66,974	31.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,574	4,753	73,962	15.56	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	939	1,070	10,128	9.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	770	770	7,363	9.57	33
34	TOTAL (lines 1 - 33)	106,330	111,186	$ 1,657,560 *	$ 14.91	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 308,691	01-03	35
36	Medical Director	Monthly	18,160	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,855	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	2,759	11-03	44
45	Social Service Consultant	Monthly	3,630	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Per Visit	1,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 339,095		49

C. CONTRACT NURSES

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashley Blevins	Administrator	0.00%	$ 37,500
Shannon Moore (1/1/14 - 5/27/14)	Administrator	0.00%	29,474
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 66,974

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 7,271
TFG Consulting	Accounting	1,824
Pinnacle Quality Insights	Customer Satisfaction	1,062
Property Valuation Services	Real Estate Assessment	100
Curaspan	Data Processing	2,550
E-Health Data Systems	Data Processing	5,190
Wescom Solutions	Data Processing	12,106
See Attached	Legal	32,154
Thomas and Thorngren	Tax Credit Services	1,005
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 63,262

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,036
Unemployment Compensation Insurance	
FICA Taxes	126,804
Employee Health Insurance	32,776
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,144
TOTAL (agree to Schedule V, line 22, col.8)	$ 242,759

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	39,598
Health Care Worker Background Check	400
(Indicate # of checks performed 39.95)	
Patient Background Checks	
Dues and Subscriptions	3,861
License and Permits	268
Allocated from Tutera HC Services	738
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,855

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,344
Allocated from Tutera HC Services	2,723
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,067

**See instructions.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Association $4,508**

(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. $ **11,548** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **194,924**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

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