

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	156	Skilled (SNF)	156	56,940	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	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,498	9,908	11,522	39,928	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,498	9,908	11,522	39,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.12%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/01/2010

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 154 and days of care provided 10,274

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		8,854	595,814	604,668		604,668		604,668		1
2	Food Purchase		30,905		30,905		30,905	(4,737)	26,168		2
3	Housekeeping		11,140	139,200	150,340		150,340		150,340		3
4	Laundry		7,593	96,504	104,097		104,097		104,097		4
5	Heat and Other Utilities			147,938	147,938		147,938	1,707	149,645		5
6	Maintenance	59,474	5,377	114,097	178,948		178,948	(9,541)	169,407		6
7	Other (specify):*										7
8	TOTAL General Services	59,474	63,869	1,093,553	1,216,896		1,216,896	(12,571)	1,204,325		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	2,346,493	132,389	8,310	2,487,192		2,487,192	48,364	2,535,556		10
10a	Therapy										10a
11	Activities	101,875	7,442	3,170	112,487		112,487		112,487		11
12	Social Services	102,921	2,329		105,250		105,250		105,250		12
13	CNA Training										13
14	Program Transportation			31	31		31		31		14
15	Other (specify):*							12,024	12,024		15
16	TOTAL Health Care and Programs	2,551,289	142,160	19,911	2,713,360		2,713,360	60,388	2,773,748		16
	C. General Administration										
17	Administrative	94,924		467,505	562,429		562,429	(467,505)	94,924		17
18	Directors Fees										18
19	Professional Services			92,494	92,494	(100)	92,394	(12,304)	80,090		19
20	Dues, Fees, Subscriptions & Promotions			67,282	67,282		67,282	(45,728)	21,554		20
21	Clerical & General Office Expenses	154,225	31,097	561,487	746,809		746,809	(313,335)	433,474		21
22	Employee Benefits & Payroll Taxes			407,315	407,315		407,315		407,315		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,841	11,841		11,841	5,121	16,962		24
25	Other Admin. Staff Transportation			10,184	10,184		10,184	32,190	42,374		25
26	Insurance-Prop.Liab.Malpractice			158,584	158,584		158,584	2,338	160,922		26
27	Other (specify):*							36,874	36,874		27
28	TOTAL General Administration	249,149	31,097	1,776,692	2,056,938	(100)	2,056,838	(762,349)	1,294,489		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,859,912	237,126	2,890,156	5,987,194	(100)	5,987,094	(714,532)	5,272,562		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

Lakeland Rehab & HCC

#0050971

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,841	31,841		31,841	289,382	321,223			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			253	253		253	218,785	219,038			32
33	Real Estate Taxes			86,400	86,400	100	86,500	1,466	87,966			33
34	Rent-Facility & Grounds			407,996	407,996		407,996	(406,716)	1,280			34
35	Rent-Equipment & Vehicles			20,904	20,904		20,904	6,354	27,258			35
36	Other (specify):*							24,703	24,703			36
37	TOTAL Ownership			547,394	547,394	100	547,494	133,974	681,468			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		406,560	1,329,855	1,736,415		1,736,415		1,736,415			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,147	257,147		257,147		257,147			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		406,560	1,587,002	1,993,562		1,993,562		1,993,562			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,859,912	643,686	5,024,552	8,528,150		8,528,150	(580,558)	7,947,592			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 Lakeland Rehab & HCC

0050971

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	5,944	30		9
10	Interest and Other Investment Income	(4,702)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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				18
19	Entertainment	(15,866)	21		19
20	Contributions	(665)	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	(302,595)	21		24
25	Fund Raising, Advertising and Promotional	(43,711)	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	(239,452)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (601,124)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	20,566		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,566		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (580,558)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Lakeland Rehab & HCC

ID# 0050971

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non-Allowable Travel	\$ (277)	25	1
2	Asset Management Fees	(196,110)	21	2
3	Vending Machine Revenue	(2,221)	02	3
4	PAC Dues	(2,490)	20	4
5	Annual Report	(250)	20	5
6	Non-Allowable Legal	(12,739)	19	6
7	Building Co - Legal Fees	(450)	19	7
8	Building Co - Accounting Fees	(6,250)	19	8
9	Building Co - Miscellaneous Expense	(27)	21	9
10	Building Co - Amortization	(3,974)	36	10
11	Capitalized R&M	(12,226)	06	11
12	Meals	(2,439)	02	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(239,452)	49

Lakeland Rehab & HCC

ID# 0050971

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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 Lakeland Rehab & HCC# 0050971

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													1
2	Food Purchase	(4,737)											(4,737)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,707								1,707	5
6	Maintenance	(12,226)		1,016	1,669								(9,541)	6
7	Other (specify):*													7
8	TOTAL General Services	(16,963)		1,016	3,376								(12,571)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			48,364									48,364	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			12,024									12,024	15
16	TOTAL Health Care and Programs			60,388									60,388	16
	C. General Administration													
17	Administrative			(444,130)		(23,375)							(467,505)	17
18	Directors Fees													18
19	Professional Services	(19,439)	6,700	201	136	97							(12,304)	19
20	Fees, Subscriptions & Promotions	(47,116)		1,388									(45,728)	20
21	Clerical & General Office Expenses	(514,598)	27	201,227	9								(313,335)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			5,121									5,121	24
25	Other Admin. Staff Transportation	(277)		32,467									32,190	25
26	Insurance-Prop.Liab.Malpractice			2,224	115								2,338	26
27	Other (specify):*			36,874									36,874	27
28	TOTAL General Administration	(581,430)	6,727	(164,628)	260	(23,278)							(762,349)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(598,393)	6,727	(103,225)	3,636	(23,278)							(714,532)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeland Rehab & HCC

0050971

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,944	272,884	8,228	2,326								289,382	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,702)	223,228		259								218,785	32
33	Real Estate Taxes			109	1,357								1,466	33
34	Rent-Facility & Grounds		(406,716)	11,644	(11,644)								(406,716)	34
35	Rent-Equipment & Vehicles			6,354									6,354	35
36	Other (specify):*	(3,974)	28,677										24,703	36
37	TOTAL Ownership	(2,732)	118,073	26,335	(7,703)								133,974	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(601,124)	124,800	(76,889)	(4,067)	(23,278)							(580,558)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 406,716	TI Effingham, LLC	100.00%	\$	\$ (406,716)	1
2	V	32 Interest	114	TI Effingham, LLC	100.00%	223,342	223,228	2
3	V	19 Legal		TI Effingham, LLC	100.00%	450	450	3
4	V	19 Accounting		TI Effingham, LLC	100.00%	6,250	6,250	4
5	V	21 Miscellaneous Expense		TI Effingham, LLC	100.00%	27	27	5
6	V	36 Mortgage Insurance Premium		TI Effingham, LLC	100.00%	24,703	24,703	6
7	V	30 Depreciation		TI Effingham, LLC	100.00%	272,884	272,884	7
8	V	36 Amortization		TI Effingham, LLC	100.00%	3,974	3,974	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 406,830			\$ 531,630	\$ * 124,800	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS, MAINTENANCE & SECUR	\$	Tutera Health Care Services	100.00%	\$ 1,016	\$ 1,016
16	V	10 NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	266	266
17	V	10 NURSING SALARIES		Tutera Health Care Services	100.00%	48,098	48,098
18	V	15 NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	12,024	12,024
19	V	19 PROFESSIONAL FEES		Tutera Health Care Services	100.00%	201	201
20	V	20 DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	1,388	1,388
21	V	21 OFFICE EXPENSES		Tutera Health Care Services	100.00%	18,762	18,762
22	V	21 OFFICE SALARIES		Tutera Health Care Services	100.00%	182,465	182,465
23	V	24 BUSINESS SEMINAR		Tutera Health Care Services	100.00%	5,121	5,121
24	V	25 TRAVEL EXPENSES		Tutera Health Care Services	100.00%	32,467	32,467
25	V	26 INSURANCE		Tutera Health Care Services	100.00%	2,224	2,224
26	V	27 EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	36,874	36,874
27	V	30 DEPRECIATION		Tutera Health Care Services	100.00%	8,228	8,228
28	V	32 INTEREST EXPENSE		Tutera Health Care Services	100.00%		
29	V	33 REAL ESTATE TAXES		Tutera Health Care Services	100.00%	109	109
30	V	34 RENTAL OF SPACE		Tutera Health Care Services	100.00%	11,644	11,644
31	V	35 EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	952	952
32	V	35 AUTO RENTAL		Tutera Health Care Services	100.00%	5,402	5,402
33	V						
34	V	17 MANAGEMENT FEES	444,130	Tutera Health Care Services	100.00%		(444,130)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 444,130			\$ 367,241	\$ * (76,889)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	Columbia 7611, LLC	100.00%	\$ 1,707	\$ 1,707
16	V	6 REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	1,669	1,669
17	V	19 PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	136	136
18	V	21 OFFICE EXPENSES		Columbia 7611, LLC	100.00%	9	9
19	V	26 INSURANCE		Columbia 7611, LLC	100.00%	115	115
20	V	30 DEPRECIATION		Columbia 7611, LLC	100.00%	2,326	2,326
21	V	32 INTEREST EXPENSE		Columbia 7611, LLC	100.00%	259	259
22	V	33 REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	1,357	1,357
23	V						
24	V	34 RENT	11,644	Columbia 7611, LLC	100.00%		(11,644)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,644			\$ 7,577	\$ * (4,067)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 467,505	Illinois Health Care Management LLC	100.00%	\$ 444,130	\$ (23,375)
16	V	19 Legal Expense		Illinois Health Care Management LLC	100.00%	97	97
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 467,505			\$ 444,227	\$ * (23,278)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Lakeland Rehab & HCC

0050971

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

Lakeland Rehab & HCC

0050971

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

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 Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE	160,764,752	31	\$ 20,697	\$ 7,890,723	\$ 1,016	1
2	10	NURSING & MEDICAL RECO	OPERATING EXPENSE	160,764,752	31	5,416	7,890,723	266	2
3	10	NURSING SALARIES	OPERATING EXPENSE	160,764,752	31	979,937	979,937	48,098	3
4	15	NURSING TAXES & BENEFITS	OPERATING EXPENSE	160,764,752	31	244,977	7,890,723	12,024	4
5	19	PROFESSIONAL FEES	OPERATING EXPENSE	160,764,752	31	4,102	7,890,723	201	5
6	20	DUES, FEES, LICENSES, MEM	OPERATING EXPENSE	160,764,752	31	28,269	7,890,723	1,388	6
7	21	OFFICE EXPENSES	OPERATING EXPENSE	160,764,752	31	382,252	7,890,723	18,762	7
8	21	OFFICE SALARIES	OPERATING EXPENSE	160,764,752	31	3,717,531	3,717,531	182,465	8
9	24	BUSINESS SEMINAR	OPERATING EXPENSE	160,764,752	31	104,327	7,890,723	5,121	9
10	25	TRAVEL EXPENSES	OPERATING EXPENSE	160,764,752	31	661,487	7,890,723	32,467	10
11	26	INSURANCE	OPERATING EXPENSE	160,764,752	31	45,302	7,890,723	2,224	11
12	27	EMP BENEFITS & PAYROLL T	OPERATING EXPENSE	160,764,752	31	751,270	7,890,723	36,874	12
13	30	DEPRECIATION	OPERATING EXPENSE	160,764,752	31	167,643	7,890,723	8,228	13
14	32	INTEREST EXPENSE	OPERATING EXPENSE	160,764,752	31		7,890,723		14
15	33	REAL ESTATE TAXES	OPERATING EXPENSE	160,764,752	31	2,226	7,890,723	109	15
16	34	RENTAL OF SPACE	OPERATING EXPENSE	160,764,752	31	237,236	7,890,723	11,644	16
17	35	EQUIPMENT RENTAL	OPERATING EXPENSE	160,764,752	31	19,392	7,890,723	952	17
18	35	AUTO RENTAL	OPERATING EXPENSE	160,764,752	31	110,058	7,890,723	5,402	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,482,120	\$ 4,697,468	\$ 367,241	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	OPERATING EXPENSE 160,764,752	31	\$ 34,777	\$	7,890,723	\$ 1,707	1
2	6	REPAIRS, MAINTENANCE & S	OPERATING EXPENSE 160,764,752	31	33,996		7,890,723	1,669	2
3	19	PROFESSIONAL FEES	OPERATING EXPENSE 160,764,752	31	2,779		7,890,723	136	3
4	21	OFFICE EXPENSES	OPERATING EXPENSE 160,764,752	31	182		7,890,723	9	4
5	26	INSURANCE	OPERATING EXPENSE 160,764,752	31	2,337		7,890,723	115	5
6	30	DEPRECIATION	OPERATING EXPENSE 160,764,752	31	47,396		7,890,723	2,326	6
7	32	INTEREST EXPENSE	OPERATING EXPENSE 160,764,752	31	5,268		7,890,723	259	7
8	33	REAL ESTATE TAXES	OPERATING EXPENSE 160,764,752	31	27,638		7,890,723	1,357	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	\$		\$ 7,577	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Direct Expense		\$	\$		\$ 444,130	1
2	19	Legal Expense	Operating Expense	20,264,854	3	250	7,890,723	97	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				\$ 250	\$		\$ 444,227	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Lakeland Rehab & HCC

0050971

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1	Mortgage - HUD		X				\$	\$ 4,898,122			\$ 223,342	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	Note Payable		X					367,000			253	6				
7	Allocated from Columbia 7611 LLC		X								259	7				
8												8				
9	TOTAL Facility Related						\$	\$ 5,265,122			\$ 223,854	9				
	B. Non-Facility Related*															
10	Interest Income		X								(4,702)	10				
11	Interest Income - Bldg Co		X								(114)	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (4,817)	14				
15	TOTALS (line 9+line14)						\$	\$ 5,265,122			\$ 219,037	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,703 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

Lakeland Rehab & HCC

0050971

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

* 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.)

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakeland Rehab & HCC COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0050971

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-11-020-019</u>	<u>Long Term Care Facility</u>	\$ <u>86,644.80</u>	\$ <u>86,644.80</u>
2. <u>47-920-06-15-02-0-00-000</u>	<u>Home Office Allocation</u>	\$ <u>69,638.00</u>	\$ <u>1,356.52</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>156,282.80</u></u>	\$ <u><u>88,001.32</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

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 Lakeland Rehab & HCC

0050971 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,500 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>		<u>2010</u>	<u>\$ 612,285</u>	<u>1</u>
2	<u>Allocated from Columbia 7611 LLC</u>			<u>5,552</u>	<u>2</u>
3	TOTALS			\$ 617,837	3

Facility Name & ID Number Lakeland Rehab & HCC

0050971

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	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	156		2010	1971	\$ 5,290,525	\$ 190,542	39	\$ 135,654	\$ (54,887)	\$ 678,272	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67			172,858	2,983		8,643	5,660	31,136
68			60,853	2,847		1,874	(973)	42,856
69				31,841			(31,841)	
70			\$ 5,524,236	\$ 228,213		\$ 146,171	\$ (82,041)	\$ 752,264

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,524,236	\$ 228,213		\$ 146,171	\$ (82,041)	\$ 752,264	1
2	Pt Rm Remod (Electrical, Framing,Drywall,Sprinkler,Cabinets, C	2011	101,949		20	5,097	5,097	10,408	2
3	Water Heater	2012	17,065		20	1,707	1,707	3,626	3
4	400 Hallway, Dining/Patient Rms-New Restrooms,Ceilings,Fire Do	2012	216,078		20	10,804	10,804	32,412	4
5	Hallway Wall Mounted Point Click Care	2012	7,336		20	367	367	1,100	5
6	Kiosks & Installation	2012	20,254		20	1,013	1,013	3,038	6
7	Remodel:400 Wing:Room #'S 423-401,Nurse Station, Lounge,	2013	195,075		20	9,754	9,754	19,507	7
8	Cont. Office & Corridor, Laundry Rm, Lobby, Offices:	2013			20				8
9	Cont. Demo, Drywall,Electrical,Plumbing,Flooring,Painting,Ceilin	2013			20				9
10	Storage Shed	2013	6,841		20	342	342	684	10
11	Office And Resident Rooms 401-404 - Flooring	2014	6,108		20	305	305	305	11
12	Office And Resident Rooms 402, 403, And 405 - Flooring	2014	6,118		20	306	306	306	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)		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	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		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	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		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	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)		\$ 6,101,058	\$ 228,213		\$ 175,866	\$ (52,347)	\$ 823,651	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	200/400 Hallways Dining Rm, Kitchen - Architect Fees, Walls, Floo	2012	157,941		20	7,897	7,897	23,691	9
10	Parking Lot Repairs	2011	14,917		20	746	746	7,445	10
11	Depreciation			2,983			(2,983)		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)		\$ 172,858	\$ 2,983		\$ 8,643	\$ 5,660	\$ 31,136	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 172,858	\$ 2,983		\$ 8,643	\$ 5,660	\$ 31,136	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)	\$ 172,858	\$ 2,983		\$ 8,643	\$ 5,660	\$ 31,136	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Columbia 7611 LLC	1989	48,003	1,872	35	1,372	(500)	35,659	3
4	Allocated from Columbia 7611 LLC	1990	5,492	201	35	157	(44)	3,923	4
5	Allocated from Columbia 7611 LLC	1991	726	27	35	21	(6)	498	5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Walnut Creek Management	2006	2,081		20	104	104	936	9
10	Allocated from Walnut Creek Management	2007	50	2	20	2		20	10
11	Allocated from Walnut Creek Management	2014	1,176	676	20	59	(617)	59	11
12									12
13	Allocated from LTC Services LLC	2001	85		20	4	4	59	13
14	Allocated from LTC Services LLC	2002	78		20	4	4	51	14
15									15
16	Allocated from Columbia 7611 LLC	1989	26		20			26	16
17	Allocated from Columbia 7611 LLC	1994	136	4	20		(4)	136	17
18	Allocated from Columbia 7611 LLC	1995	212	6	20	11	5	212	18
19	Allocated from Columbia 7611 LLC	1996	393	7	20	20	13	374	19
20	Allocated from Columbia 7611 LLC	2003	153	5	20	8	3	92	20
21	Allocated from Columbia 7611 LLC	2006	743		20	37	37	335	21
22	Allocated from Columbia 7611 LLC	2008	1,173	37	20	59	22	411	22
23	Allocated from Columbia 7611 LLC	2011	326	10	20	16	6	65	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)		\$ 60,853	\$ 2,847		\$ 1,874	\$ (973)	\$ 42,856	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 60,853	\$ 2,847		\$ 1,874	\$ (973)	\$ 42,856	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)		\$ 60,853	\$ 2,847		\$ 1,874	\$ (973)	\$ 42,856	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,400,680	\$ 85,236	\$ 132,982	\$ 47,745	10	\$ 794,209	71
72	Current Year Purchases	2,089	1,402	209	(1,193)	10	209	72
73	Fully Depreciated Assets	14,466	159	403	244	10	14,466	73
74								74
75	TOTALS	\$ 1,417,235	\$ 86,797	\$ 133,594	\$ 46,796		\$ 808,884	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Van	2013	\$ 57,587	\$	\$ 11,517	\$ 11,517	5	\$ 23,034	76
77		Allocated from Walnut Creek M	2014	5,287	271	248	(23)	5	4,791	77
78		Allocated from LTC Services LL	2014	1,968				5	1,968	78
79										79
80	TOTALS			\$ 64,842	\$ 271	\$ 11,765	\$ 11,494		\$ 29,793	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)	\$ 8,200,972	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 315,281	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 321,225	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,944	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,662,329	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

Lakeland Rehab & HCC

0050971

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 Rental				1,280			5
6								6
7	TOTAL				\$ 1,280			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 21,856

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 Tutores HC Services		\$	\$ 5,402	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 5,402	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 Lakeland Rehab & HCC # 0050971 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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	422,153	\$		\$	422,153	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				135,997				135,997	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				711,426		161		711,587	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 prescripts						270,848		270,848	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						60,279		135,551		195,830	13
14	TOTAL			\$		\$	1,329,855	\$	406,560	\$	1,736,415	14

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

Facility Name & ID Number Lakeland Rehab & HCC# 0050971Report 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	\$ 3,394	\$ 39,378	1
2	Cash-Patient Deposits	12,834	12,834	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,397,722	1,397,722	3
4	Supply Inventory (priced at)	9,765	9,765	4
5	Short-Term Investments			5
6	Prepaid Insurance	339,222	338,357	6
7	Other Prepaid Expenses	48,037	62,288	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	66,057	269,727	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,877,031	\$ 2,130,071	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		612,285	13
14	Buildings, at Historical Cost		5,239,904	14
15	Leasehold Improvements, at Historical Cost	314,189	329,106	15
16	Equipment, at Historical Cost	102,707	657,263	16
17	Accumulated Depreciation (book methods)	(116,906)	(1,397,087)	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):	84,124	157,228	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 384,114	\$ 5,598,699	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,261,145	\$ 7,728,770	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 244,191	\$ 244,193	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,834	12,834	28
29	Short-Term Notes Payable	367,000	367,000	29
30	Accrued Salaries Payable	170,954	170,954	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,621	54,621	31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,759	84,514	32
33	Accrued Interest Payable		18,450	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)	\$ 934,359	\$ 952,566	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,898,122	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	203,670	196,110	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 203,670	\$ 5,094,232	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,138,029	\$ 6,046,798	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,123,116	\$ 1,681,972	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,261,145	\$ 7,728,770	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 945,865	1
2	Restatements (describe):		2
3	Prior Year Asset Management Fees	(196,110)	3
4	Equity Restatement	(455,731)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 294,024	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	829,092	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 829,092	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,123,116	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,624,940	1
2	Discounts and Allowances for all Levels	(979,875)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,645,065	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,922,569	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,922,569	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	569,988	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,919	19
20	Radiology and X-Ray		20
21	Other Medical Services	186,778	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 782,685	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,702	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,702	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,221	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,221	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,357,242	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,216,896	31
32	Health Care	2,713,360	32
33	General Administration	2,056,938	33
B. Capital Expense			
34	Ownership	547,394	34
C. Ancillary Expense			
35	Special Cost Centers	1,736,415	35
36	Provider Participation Fee	257,147	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,528,150	40
41	Income before Income Taxes (line 30 minus line 40)**	829,092	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 829,092	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,276,934	44
45	Private Pay - Net Inpatient Revenue	1,567,874	45
46	Medicare - Net Inpatient Revenue	1,642,729	46
47	Other-(specify) <u>Insurance</u>	157,528	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,645,065	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 Lakeland Rehab & HCC

0050971

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	8,188	8,861	\$ 246,122	\$ 27.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,470	18,317	450,034	24.57	3
4	Licensed Practical Nurses	26,335	28,039	545,326	19.45	4
5	CNAs & Orderlies	93,831	97,037	1,058,050	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,793	8,275	101,875	12.31	10
11	Social Service Workers	6,575	7,078	102,921	14.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,840	4,301	59,474	13.83	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,872	2,139	94,924	44.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,508	11,281	154,225	13.67	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	1,493	1,589	18,921	11.91	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,191	2,224	28,040	12.61	33
34	TOTAL (lines 1 - 33)	180,096	189,141	\$ 2,859,912 *	\$ 15.12	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 595,814	01-03	35
36	Medical Director	Monthly	8,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,310	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	3,170	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 615,694		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
William Wade	Administrator	0.00%	\$ 94,924	Workers' Compensation Insurance	\$ 108,426	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	12,241	
				FICA Taxes	218,783	Health Care Worker Background Check	37	
				Employee Health Insurance	80,105	(Indicate # of checks performed <u>7</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	5,748	
						License and Permits	150	
						Advertising and Promotions	43,711	
						Allocated from Tutera HC Services	1,388	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,924			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(43,711)	
Description			Amount			Yellow page advertising	()	
IL Health Care Management - Management Fees			\$ 467,505			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,554	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 467,505	TOTAL (agree to Schedule V, line 22, col.8)		\$ 407,314		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg, & Rothblatt	Accounting		\$ 7,000				Out-of-State Travel	\$
Gottlieb, Flekier & Co.	Accounting		1,860					
Pinnacle Quality Insights	Customer Satisfaction		1,741					
Property Valuation Services	R/E Tax Assessment		100				In-State Travel	
Curaspan	Data Processing		2,550					
E-Health Data Solutions	Data Processing		5,190					
Emdeon	Data Processing		417					
Wescom Solutions	Data Processing		21,129				Seminar Expense	11,841
Forte LLC	Data Processing		140				Allocated from Tutera HC Services	5,121
Thomas and Thorngren	Tax Credit Services		1,005					
See Attached	Legal		51,363					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 92,494	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 16,962

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Lakeland Rehab & HCC

0050971

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 \$6,486
- (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. \$ 13,253 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. \$ 257,147
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. \$ No 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.