FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049239

Facility Name: Carlinville Rehabilitation & Health Care Center

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	15,092	3,484	4,480	23,056	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,092	3,484	4,480	23,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.46%

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 2,780

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Cer # 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		3,867	314,155	318,022		318,022		318,022			1
2	Food Purchase		13,420		13,420		13,420	(5,035)	8,385			2
3	Housekeeping		8,991	106,930	115,921		115,921		115,921			3
4	Laundry		10,328	65,695	76,023		76,023		76,023			4
5	Heat and Other Utilities			80,682	80,682		80,682	1,320	82,002			5
6	Maintenance	34,002	4,238	82,400	120,640		120,640	(2,112)	118,528			6
7	Other (specify):*											7
8	**TOTAL General Services**	34,002	40,844	649,862	724,708		724,708	(5,827)	718,881			8
	B. Health Care and Programs											
9	Medical Director			11,250	11,250		11,250		11,250			9
10	Nursing and Medical Records	1,458,723	108,814	10,073	1,577,610		1,577,610	28,449	1,606,059			10
10a	Therapy											10a
11	Activities	54,860	8,530	3,691	67,081		67,081		67,081			11
12	Social Services	62,932			62,932		62,932	(1,795)	61,137			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,452	7,452			15
16	**TOTAL Health Care and Programs**	1,576,515	117,344	25,014	1,718,873		1,718,873	34,106	1,752,979			16
	C. General Administration											
17	Administrative	70,616			70,616		70,616		70,616			17
18	Directors Fees											18
19	Professional Services			109,479	109,479	(100)	109,379	(27,295)	82,084			19
20	Dues, Fees, Subscriptions & Promotions			47,514	47,514		47,514	(34,375)	13,139			20
21	Clerical & General Office Expenses	72,245	16,492	96,666	185,403		185,403	59,837	245,240			21
22	Employee Benefits & Payroll Taxes			234,406	234,406		234,406		234,406			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,349	1,349		1,349	3,221	4,570			24
25	Other Admin. Staff Transportation			12,904	12,904		12,904	13,863	26,767			25
26	Insurance-Prop.Liab.Malpractice			179,991	179,991		179,991	1,218	181,209			26
27	Other (specify):*							23,845	23,845			27
28	**TOTAL General Administration**	142,861	16,492	682,309	841,662	(100)	841,562	40,313	881,875			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,753,378	174,680	1,357,185	3,285,243	(100)	3,285,143	68,592	3,353,735			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 Rehabilitation & Health Care Center #0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			9,702	9,702		9,702	98,260	107,962			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,187	1,187		1,187	73,601	74,788			32
33	Real Estate Taxes			48,000	48,000	100	48,100	731	48,831			33
34	Rent-Facility & Grounds			207,429	207,429		207,429	(206,418)	1,011			34
35	Rent-Equipment & Vehicles			12,488	12,488		12,488	2,040	14,528			35
36	Other (specify):*							14,905	14,905			36
37	**TOTAL Ownership**			278,806	278,806	100	278,906	(16,881)	262,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200,058	464,913	664,971		664,971		664,971			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,924	176,924		176,924		176,924			42
43	Other (specify):*			348	348		348	(348)				43
44	**TOTAL Special Cost Centers**		200,058	642,185	842,243		842,243	(348)	841,895			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,753,378	374,738	2,278,176	4,406,292		4,406,292	51,363	4,457,655			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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	39,682	30		9
10	Interest and Other Investment Income	(1,681)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(8,223)	21		18
19	Entertainment	(13,744)	21		19
20	Contributions	(548)	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	(41,300)	21		24
25	Fund Raising, Advertising and Promotional	(31,358)	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	(26,647)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (83,840)		$	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)	135,202		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 135,202		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 51,363		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

STATE OF ILLINOIS

Carlinville Rehabilitation & Health Care Center

ID# 0049239

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (40)	21	1
2	Building Company Legal and Accounting	(9,628)	19	2
3	Building Company Amortization	(1,459)	36	3
4	Capitalized R&M	(2,944)	06	4
5	Marketing Expense	(348)	43	5
6	PAC Dues	(2,895)	20	6
7	Non-Allowable Legal	(2,523)	19	7
8	Meals	(5,015)	02	8
9	Social Service Refund	(1,795)	12	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,647)		49

Carlinville Rehabilitation & Health Care Center

ID# 0049239

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center **#** 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(5,035)											(5,035)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,320								1,320	5
6	Maintenance	(2,944)			832								(2,112)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(7,979)			2,153								(5,827)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			28,449									28,449	10
10a	Therapy													10a
11	Activities													11
12	Social Services	(1,795)											(1,795)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,452									7,452	15
16	**TOTAL Health Care and Programs**	(1,795)		35,901									34,106	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(12,151)	9,628	(24,795)	23								(27,295)	19
20	Fees, Subscriptions & Promotions	(34,801)		426									(34,375)	20
21	Clerical & General Office Expenses	(63,307)		123,138	5								59,837	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			3,221									3,221	24
25	Other Admin. Staff Transportation			13,863									13,863	25
26	Insurance-Prop.Liab.Malpractice			1,157	60								1,218	26
27	Other (specify):*			23,845									23,845	27
28	**TOTAL General Administration**	(110,259)	9,628	140,855	89								40,313	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,034)	9,628	176,756	2,242								68,592	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	39,682	54,218	3,146	1,213								98,260	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,681)	75,163		119								73,601	32
33	Real Estate Taxes			49	682								731	33
34	Rent-Facility & Grounds		(206,418)	5,434	(5,434)								(206,418)	34
35	Rent-Equipment & Vehicles			2,040									2,040	35
36	Other (specify):*	(1,459)	16,364										14,905	36
37	**TOTAL Ownership**	36,542	(60,673)	10,669	(3,419)								(16,881)	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):*	(348)											(348)	43
44	**TOTAL Special Cost Centers**	(348)											(348)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(83,840)	(51,045)	187,425	(1,177)								51,363	45

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Rental Income	$ 206,418	TI - Carlinville	100.00%	$	$ (206,418)	1
2	V	32	Interest	155	TI - Carlinville	100.00%	75,318	75,163	2
3	V	19	Legal & Accounting		TI - Carlinville	100.00%	9,628	9,628	3
4	V	36	Mortgage Insurance		TI - Carlinville	100.00%	14,905	14,905	4
5	V	30	Depreciation		TI - Carlinville	100.00%	54,218	54,218	5
6	V	36	Amortization		TI - Carlinville	100.00%	1,459	1,459	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 206,573			$ 155,528	$ * (51,045)	14

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	97	$ 97	15
16	V	10	NURSING SALARIES		Tutera Health Care Services	100.00%	28,352	28,352	16
17	V	15	NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	7,452	7,452	17
18	V	19	PROFESSIONAL FEES		Tutera Health Care Services	100.00%	2,205	2,205	18
19	V	20	DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	426	426	19
20	V	21	OFFICE EXPENSES		Tutera Health Care Services	100.00%	12,647	12,647	20
21	V	21	OFFICE SALARIES		Tutera Health Care Services	100.00%	110,491	110,491	21
22	V	24	BUSINESS SEMINAR		Tutera Health Care Services	100.00%	3,221	3,221	22
23	V	25	TRAVEL EXPENSES		Tutera Health Care Services	100.00%	13,863	13,863	23
24	V	26	INSURANCE		Tutera Health Care Services	100.00%	1,157	1,157	24
25	V	27	EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	23,845	23,845	25
26	V	30	DEPRECIATION		Tutera Health Care Services	100.00%	3,146	3,146	26
27	V	33	REAL ESTATE TAXES		Tutera Health Care Services	100.00%	49	49	27
28	V	34	RENTAL OF SPACE		Tutera Health Care Services	100.00%	5,434	5,434	28
29	V	35	EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	330	330	29
30	V	35	AUTO RENTAL		Tutera Health Care Services	100.00%	1,710	1,710	30
31	V								31
32	V	19	DATA PROCESSING	27,000				(27,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,000			$ 214,425	$ * 187,425	39

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 1,320	$ 1,320	15
16	V	6	REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	832	832	16
17	V	19	PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	23	23	17
18	V	21	OFFICE EXPENSES		Columbia 7611, LLC	100.00%	5	5	18
19	V	26	INSURANCE		Columbia 7611, LLC	100.00%	60	60	19
20	V	30	DEPRECIATION		Columbia 7611, LLC	100.00%	1,213	1,213	20
21	V	32	INTEREST EXPENSE		Columbia 7611, LLC	100.00%	119	119	21
22	V	33	REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	682	682	22
23	V	34	RENTAL INCOME	5,434				(5,434)	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			$ 5,434			$ 4,257	$ * (1,177)	39

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	100.00%	Auburn Rehabilitation & Health Care Center	Auburn, IL	TI-Carlinville	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 Comm	Overland Park, KS	Assisted Living	14
15			Montgomery Children's Specialty Center	Montgomery, AL	Oakley Courts Assisted Living Com	Freeport, IL	Assisted Living	15
16			Moweaqua Rehabilitation & Health Care Center	Moweaqua, IL	Rose Estates Assisted Living Comm	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons Memory Care	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Living Commu	Kansas City, KS	Independent/Assisted Living	18
19			Charlton Place Rehabilitation & Health Care Center	Deatsville, AL	Wesley Court Assisted Living Comm	Boiling Springs, SC	Assisted Living	19
20			Stratford Commons Rehabilitation & Health Care Center	Overland Park, KS	Willow Place Assisted Living & Me	Laurinburg, NC	Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Care Center	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Center	Hannibal, MO				22
23			Woodlawn Rehabilitation & Health Care Center	Wichita, KS				23
24			Holly Hill House	Sulphur, LA				24
25			Rosewood Nursing Center	Lake Charles, LA				25
26			Beautiful Savior	Belton, MO				26
27			Coulterville Rabilitation & Health Care Center	Coulterville, IL				27
28			Greenfield Manor	Greenfield, IA				28
29			Griswold Care Center	Griswold, IA				29
30			Close to Home	Matthews, MO				30

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			Holly Ridge	Dexter, MO				1
2			Ramsey Creek	Scott City, MO				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 Rehabilitation & Health Care Ce # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	NURSING & MEDICAL RECOR	OPERATING EXPENSE	167,826,743	38	3,889		4,182,170	97	1
2	10	NURSING SALARIES	OPERATING EXPENSE	167,826,743	38	1,137,749	1,137,749	4,182,170	28,352	2
3	15	NURSING TAXES & BENEFITS	OPERATING EXPENSE	167,826,743	38	299,032		4,182,170	7,452	3
4	19	PROFESSIONAL FEES	OPERATING EXPENSE	167,826,743	38	88,474		4,182,170	2,205	4
5	20	DUES, FEES, LICENSES, MEMB	OPERATING EXPENSE	167,826,743	38	17,081		4,182,170	426	5
6	21	OFFICE EXPENSES	OPERATING EXPENSE	167,826,743	38	507,506		4,182,170	12,647	6
7	21	OFFICE SALARIES	OPERATING EXPENSE	167,826,743	38	4,433,923	4,433,923	4,182,170	110,491	7
8	24	BUSINESS SEMINAR	OPERATING EXPENSE	167,826,743	38	129,254		4,182,170	3,221	8
9	25	TRAVEL EXPENSES	OPERATING EXPENSE	167,826,743	38	556,315		4,182,170	13,863	9
10	26	INSURANCE	OPERATING EXPENSE	167,826,743	38	46,444		4,182,170	1,157	10
11	27	EMP BENEFITS & PAYROLL T	OPERATING EXPENSE	167,826,743	38	956,875		4,182,170	23,845	11
12	30	DEPRECIATION	OPERATING EXPENSE	167,826,743	38	126,260		4,182,170	3,146	12
13	33	REAL ESTATE TAXES	OPERATING EXPENSE	167,826,743	38	1,969		4,182,170	49	13
14	34	RENTAL OF SPACE	OPERATING EXPENSE	167,826,743	38	218,043		4,182,170	5,434	14
15	35	EQUIPMENT RENTAL	OPERATING EXPENSE	167,826,743	38	13,230		4,182,170	330	15
16	35	AUTO RENTAL	OPERATING EXPENSE	167,826,743	38	68,623		4,182,170	1,710	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,604,665	$ 5,571,671		$ 214,425	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	167,826,743	38	$ 52,990	$	4,182,170	$ 1,320	1
2	6	REPAIRS, MAINTENANCE & SI	OPERATING EXPENSE	167,826,743	38	33,391		4,182,170	832	2
3	19	PROFESSIONAL FEES	OPERATING EXPENSE	167,826,743	38	942		4,182,170	23	3
4	21	OFFICE EXPENSES	OPERATING EXPENSE	167,826,743	38	220		4,182,170	5	4
5	26	INSURANCE	OPERATING EXPENSE	167,826,743	38	2,422		4,182,170	60	5
6	30	DEPRECIATION	OPERATING EXPENSE	167,826,743	38	48,695		4,182,170	1,213	6
7	32	INTEREST EXPENSE	OPERATING EXPENSE	167,826,743	38	4,794		4,182,170	119	7
8	33	REAL ESTATE TAXES	OPERATING EXPENSE	167,826,743	38	27,363		4,182,170	682	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					$ 170,817	$		$ 4,257	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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5										5
6										6
7										7
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20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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5										5
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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5										5
6										6
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20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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6										6
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20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Carlinville Rehabilitation & Health Care Cen # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tutera Investments		X				$	$ 416,000			$ 1,187	1
2	TI - Carlinville LLC - HUD		X	Mortgage				2,862,999			75,318	2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Columbia 7611 LLC		X								119	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,278,999			$ 76,624	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,681)	10
11	Interest Income- Bldg Co.		X								(155)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,836)	14
15	TOTALS (line 9+line14)						$	$ 3,278,999			$ 74,788	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 14,905 **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 Rehabilitation & Health Care Cen # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 51,592	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.)		$ 40,146	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,446)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,177	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.		$ 48,831	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	39,368	8
	2011	37,473	9
	2012	38,313	10
	2013	38,721	11
	2014	39,415	12

2015 Accrual: $39,415 x 1.53 = $60,177 (Rounded)
Allocated from Tutera HC Services: $49
Allocated from Columbia 7611 LLC: $682
Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlinville Rehabilitation & Health Care Center 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 2014 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 2014.

	(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	$ 39,415.30	$ 39,415.30
2.	47-920-06-15-02-0-00-000	Home Office Allocation	$ 69,332.69	$ 681.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,747.99	$ 40,097.18

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Rehabilitation & Health Care Center 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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			2,803	2
3	TOTALS			$ 194,803	3

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 54,218	35	$ 56,229	$ 2,011	$ 583,438	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	4,300		20	215	215	2,293	9
10	Various			2010	23,043		20	1,152	1,152	8,385	10
11											11
12											12
13											13
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31											31
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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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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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64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		329,401			16,740	16,740	49,410	67
68	Related Party Allocations (Pages 12H & 12I)		30,724	1,198		940	(258)	22,578	68
69	Financial Statement Depreciation			9,702			(9,702)		69
70	TOTAL (lines 4 thru 69)		$ 3,076,435	$ 65,118		$ 75,276	$ 10,158	$ 666,104	70

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,076,435	$ 65,118		$ 75,276	$ 10,158	$ 666,104	1
2	Backflow Preventor	2012	6,590		20	330	330	4,449	2
3	Wireless Infrastructure & Wiring	2012	19,293		20	965	965	2,894	3
4	Building Renovations -Part 2	2013	5,538		20	277	277	831	4
5	Asphalt Replacement- Parking Lot	2015	11,900		20	595	595	595	5
6	Arch Roofing And Restoration	2015	5,980		20	299	299	299	6
7	Sprinkler Replacement	2015	2,944		20	147	147	147	7
8									8
9									9
10									10
11									11
12									12
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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	TOTAL (lines 1 thru 33)		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	1
2									2
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	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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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)		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	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)		$ 3,128,679	$ 65,118		$ 77,888	$ 12,770	$ 675,319	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Building Company		$	$		$	$	$	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	16,740	16,740	49,410	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	$		$ 16,740	$ 16,740	$ 49,410	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 16,740	$ 16,740	$ 49,410	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
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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	$		$ 16,740	$ 16,740	$ 49,410	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Columbia 7611 LLC	1989	24,235	965	35	692	(273)	18,696	3
4	Allocated From Columbia 7611 LLC	1990	2,773	110	35	79	(31)	2,060	4
5	Allocated From Columbia 7611 LLC	1991	366	15	35	10	(5)	262	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Walnut Creek Management	2006	1,052		20	53	53	526	9
10	Allocated From Walnut Creek Management	2007	25		20	1	1	11	10
11	Allocated From Walnut Creek Management	2014	594	73	20	30	(43)	59	11
12									12
13	Allocated From LTC Service LLC	2001	43		20	2	2	32	13
14	Allocated From LTC Service LLC	2002	40		20	2	2	28	14
15									15
16	Allocated From Columbia 7611 LLC	1989	13		20			13	16
17	Allocated From Columbia 7611 LLC	1994	69	2	20		(2)	69	17
18	Allocated From Columbia 7611 LLC	1995	107	3	20		(3)	107	18
19	Allocated From Columbia 7611 LLC	1996	199	4	20	10	6	199	19
20	Allocated From Columbia 7611 LLC	2003	77	2	20	4	2	50	20
21	Allocated From Columbia 7611 LLC	2006	375		20	19	19	188	21
22	Allocated From Columbia 7611 LLC	2008	592	19	20	30	11	237	22
23	Allocated From Columbia 7611 LLC	2011	164	5	20	8	3	41	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)		$ 30,724	$ 1,198		$ 940	$ (258)	$ 22,578	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 30,724	$ 1,198		$ 940	$ (258)	$ 22,578	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)		$ 30,724	$ 1,198		$ 940	$ (258)	$ 22,578	34

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 304,482	$ 2,925	$ 29,254	$ 26,329	10	$ 190,639	71
72	Current Year Purchases	6,948	37	695	658	10	695	72
73	Fully Depreciated Assets	7,313	88		(88)	10	7,313	73
74								74
75	TOTALS	$ 318,743	$ 3,050	$ 29,949	$ 26,899		$ 198,647	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 M	2015	$ 2,673	$ 112	$ 125	$ 13	5	$ 2,547	76
77		Allcoated From LTC Services LL	2015	995				5	995	77
78										78
79										79
80	TOTALS			$ 3,668	$ 112	$ 125	$ 13		$ 3,542	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)	$	3,645,893	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	68,280	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	107,962	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	39,682	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	877,508	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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Stoage Unit				1,011			6
7	TOTAL				$ 1,011 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 12,818 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		$	$ 1,710	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,710	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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 175,818	$		$ 175,818	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			69,825	42		69,867	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			168,662	765		169,427	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				119,857		119,857	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					50,608	79,394		130,002	13
14	TOTAL			$		$ 464,913	$ 200,058		$ 664,971	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 Rehabilitation & Health Care Center **#** 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 294,964	$ 304,157	1
2	Cash-Patient Deposits	41,282	41,282	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	854,164	854,164	3
4	Supply Inventory (priced at)	8,019	8,019	4
5	Short-Term Investments			5
6	Prepaid Insurance	149,198	156,095	6
7	Other Prepaid Expenses	15,985	15,985	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	49,769	302,810	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,413,381	$ 1,682,512	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		2,319,393	14
15	Leasehold Improvements, at Historical Cost	54,883	54,883	15
16	Equipment, at Historical Cost	52,672	305,878	16
17	Accumulated Depreciation (book methods)	(95,509)	(758,313)	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):	6,098	58,605	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,144	$ 2,172,446	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,431,525	$ 3,854,958	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 278,577	$ 278,577	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,282	41,282	28
29	Short-Term Notes Payable	416,000	416,000	29
30	Accrued Salaries Payable	104,788	104,788	30
31	Accrued Taxes Payable (excluding real estate taxes)	97,580	97,580	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,313	60,177	32
33	Accrued Interest Payable		6,203	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	45,583	45,583	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,022,123	$ 1,050,190	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,863,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,863,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,022,123	$ 3,913,190	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 409,402	$ (58,232)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,431,525	$ 3,854,958	48

***(See instructions.)**

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center **#** 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 518,821	1
2	Restatements (describe):		2
3	**Prepaid Taxes/Distributions**	903,782	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,422,603	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,799)	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	(977,402)	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)**	$ (1,013,201)	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)**	$ 409,402	24 *

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

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 3,094,616	1
2	Discounts and Allowances for all Levels	(87,319)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,007,297	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	996,531	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 996,531	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	284,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,258	19
20	Radiology and X-Ray		20
21	Other Medical Services	65,666	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 363,149	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,681	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,681	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,835	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,835	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,370,493	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	724,708	31
32	Health Care	1,718,873	32
33	General Administration	841,662	33
	B. Capital Expense		
34	Ownership	278,806	34
	C. Ancillary Expense		
35	Special Cost Centers	665,319	35
36	Provider Participation Fee	176,924	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,406,292	40
41	**Income before Income Taxes (line 30 minus line 40)****	(35,799)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (35,799)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,896,683	44
45	Private Pay - Net Inpatient Revenue	558,786	45
46	Medicare - Net Inpatient Revenue	396,018	46
47	Other-(specify) Insurance	155,810	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,007,297	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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	6,625	7,229	$ 231,838	$ 32.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,873	6,103	132,333	21.68	3
4	Licensed Practical Nurses	18,854	20,088	447,321	22.27	4
5	CNAs & Orderlies	46,442	47,867	626,727	13.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,059	4,337	54,860	12.65	10
11	Social Service Workers	3,116	3,260	62,932	19.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,072	2,201	34,002	15.45	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,872	2,000	70,616	35.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,069	4,432	72,245	16.30	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	1,155	1,179	13,773	11.68	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	582	582	6,731	11.57	33
34	TOTAL (lines 1 - 33)	94,719	99,278	$ 1,753,378 *	$ 17.66	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	$ 314,155	01-03	35
36	Medical Director	Monthly	11,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,573	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	3,691	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	5,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 339,169		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 Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashley Blevins	Administrator	0.00%	$ 64,261
Alisha Sinclair	Administrator	0.00%	6,355
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,616

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/Marcum	Accounting	$ 7,281
TFG Consulting	Accounting	1,824
Kronos	Data Processing	17,617
Tutera Health Care Services	Data Processing	27,000
E-Health Data	Data Processing	5,190
Medifax	Data Processing	350
Wescom	Data Processing	15,352
Curaspan	Data Processing	1,700
See Attached	Legal	31,603
Pinnacle Quality Insights	Customer Satisfaction	1,462
Property Valuation Services	Appraisal	100
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 109,479

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,142
Unemployment Compensation Insurance	35,606
FICA Taxes	134,133
Employee Health Insurance	46,730
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	794
TOTAL (agree to Schedule V, line 22, col.8)	$ 234,405

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	
Health Care Worker Background Check	
(Indicate # of checks performed 167)	1,665
Patient Background Checks	
Advertising & Promotions	31,358
Licenses	1,157
Dues & Subscriptions	7,901
Allocated From Tutera HC Services	426
Less: Public Relations Expense	( )
Non-allowable advertising	(31,358)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,139

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,349
Allocated From Tutera HC Services	3,221
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,570

**See instructions.

Facility Name & ID Number Carlinville Rehabilitation & Health Care Center # 0049239 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Rehabilitation & Health Care Center # 0049239 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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. **Illinois Health Care Association $7,683**

(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. $ **12,962** Line **10-02**

(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. $ **176,924**
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? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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.