FOR BHF USE

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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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0049239

Facility Name: Carlinville Rehab & HCC

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

County: Macoupin

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kevin Wellen, CPA **Telephone Number:** 314-925-4446
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 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4300 Fax # 314-925-4350

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,868	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	35,868	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	14,983	3,632	3,798	22,413	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,983	3,632	3,798	22,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.49%

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 1,945

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		4,523	307,716	312,239		312,239		312,239			1
2	Food Purchase		13,270		13,270		13,270		13,270			2
3	Housekeeping		8,510	106,248	114,758		114,758		114,758			3
4	Laundry		9,703	65,411	75,114		75,114		75,114			4
5	Heat and Other Utilities			81,515	81,515		81,515		81,515			5
6	Maintenance	27,859	9,935	57,281	95,075		95,075	24,058	119,133			6
7	Other (specify):*											7
8	TOTAL General Services	27,859	45,941	618,171	691,971		691,971	24,058	716,029			8
	B. Health Care and Programs											
9	Medical Director					13,000	13,000		13,000			9
10	Nursing and Medical Records	1,262,051	82,244	28,494	1,372,789	(13,000)	1,359,789	2,524	1,362,313			10
10a	Therapy											10a
11	Activities	58,901	11,778	3,205	73,884		73,884		73,884			11
12	Social Services	55,953		2,842	58,795		58,795		58,795			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,376,905	94,022	34,541	1,505,468		1,505,468	2,524	1,507,992			16
	C. General Administration											
17	Administrative	56,755			56,755		56,755		56,755			17
18	Directors Fees											18
19	Professional Services			84,352	84,352		84,352	194,724	279,076			19
20	Dues, Fees, Subscriptions & Promotions			14,175	14,175		14,175	(2,555)	11,620			20
21	Clerical & General Office Expenses	78,772	16,231	126,813	221,816		221,816	(92,962)	128,854			21
22	Employee Benefits & Payroll Taxes			248,541	248,541		248,541		248,541			22
23	Inservice Training & Education					16	16		16			23
24	Travel and Seminar			1,766	1,766	(16)	1,750		1,750			24
25	Other Admin. Staff Transportation			9,110	9,110		9,110		9,110			25
26	Insurance-Prop.Liab.Malpractice			146,942	146,942		146,942	276	147,218			26
27	Other (specify):*											27
28	TOTAL General Administration	135,527	16,231	631,699	783,457		783,457	99,483	882,940			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,540,291	156,194	1,284,411	2,980,896		2,980,896	126,065	3,106,961			29

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

Facility Name & ID Number Carlinville Rehab & HCC #0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			11,234	11,234		11,234	75,145	86,379			30
31	Amortization of Pre-Op. & Org.							1,750	1,750			31
32	Interest			957	957		957	72,018	72,975			32
33	Real Estate Taxes			48,000	48,000		48,000	(7,884)	40,116			33
34	Rent-Facility & Grounds			206,418	206,418		206,418	(206,418)				34
35	Rent-Equipment & Vehicles			12,255	12,255		12,255		12,255			35
36	Other (specify):* **Mortgage Ins**							12,471	12,471			36
37	**TOTAL Ownership**			278,864	278,864		278,864	(52,918)	225,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,022	407,509	586,531		586,531		586,531			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,553	178,553		178,553		178,553			42
43	Other (specify):* **Marketing**			35,340	35,340		35,340	(35,340)				43
44	**TOTAL Special Cost Centers**		179,022	621,402	800,424		800,424	(35,340)	765,084			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,540,291	335,216	2,184,677	4,060,184		4,060,184	37,807	4,097,991			45

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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				9
10	Interest and Other Investment Income	(1,220)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,643)	21		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	(6,760)	21		18
19	Entertainment	(16,257)	21		19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,856)	21		24
25	Fund Raising, Advertising and Promotional	(35,340)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,595)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (133,171)		$	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)	170,978		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 170,978		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 37,807		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

Carlinville Rehab & HCC

ID# 0049239

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (40)	21	1
2	Lobbying Portion of IHA Dues	(2,555)	20	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
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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**	(2,595)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlinville Rehab & HCC **#** 0049239 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	24,058	0	0	0	0	0	0	0	0	0	24,058	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	24,058	0	0	0	0	0	0	0	0	0	24,058	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,524	0	0	0	0	0	0	0	0	0	2,524	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,524	0	0	0	0	0	0	0	0	0	2,524	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,986	185,738	0	0	0	0	0	0	0	0	194,724	19
20	Fees, Subscriptions & Promotions	(2,555)	0	0	0	0	0	0	0	0	0	0	(2,555)	20
21	Clerical & General Office Expenses	(94,056)	1,094	0	0	0	0	0	0	0	0	0	(92,962)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	276	0	0	0	0	0	0	0	0	0	276	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(96,611)	10,356	185,738	0	0	0	0	0	0	0	0	99,483	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(96,611)	36,938	185,738	0	0	0	0	0	0	0	0	126,065	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlinville Rehab & HCC **#** 0049239 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	67,743	7,402	0	0	0	0	0	0	0	0	75,145	30
31	Amortization of Pre-Op. & Org.	0	1,750	0	0	0	0	0	0	0	0	0	1,750	31
32	Interest	(1,220)	73,238	0	0	0	0	0	0	0	0	0	72,018	32
33	Real Estate Taxes	0	(7,884)	0	0	0	0	0	0	0	0	0	(7,884)	33
34	Rent-Facility & Grounds	0	(206,418)	0	0	0	0	0	0	0	0	0	(206,418)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	12,471	0	0	0	0	0	0	0	0	0	12,471	36
37	**TOTAL Ownership**	(1,220)	(59,100)	7,402	0	0	0	0	0	0	0	0	(52,918)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(35,340)	0	0	0	0	0	0	0	0	0	0	(35,340)	43
44	**TOTAL Special Cost Centers**	(35,340)	0	0	0	0	0	0	0	0	0	0	(35,340)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(133,171)	(22,162)	193,140	0	0	0	0	0	0	0	0	37,807	45

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Tutera Investments - Carlinville	100.00%	$	$ (206,418)	1
2	V	32	Interest		Tutera Investments - Carlinville	100.00%	73,238	73,238	2
3	V	19	Legal & Accounting		Tutera Investments - Carlinville	100.00%	450	450	3
4	V	36	Mortgage Insurance		Tutera Investments - Carlinville	100.00%	12,471	12,471	4
5	V	30	Depreciation		Tutera Investments - Carlinville	100.00%	67,743	67,743	5
6	V	31	Amortization		Tutera Investments - Carlinville	100.00%	1,750	1,750	6
7	V	33	Real Estate Taxes	48,000	Tutera Investments - Carlinville	100.00%	40,116	(7,884)	7
8	V	26	Insurance	7,200	Tutera Investments - Carlinville	100.00%	7,476	276	8
9	V	6	Maintenance		Tutera Investments - Carlinville	100.00%	24,058	24,058	9
10	V	21	Small Equipment		Tutera Investments - Carlinville	100.00%	1,094	1,094	10
11	V	19	Accounting Fee		Tutera Investments - Carlinville	100.00%	8,536	8,536	11
12	V	10	Nursing Admin Small Equip		Tutera Investments - Carlinville	100.00%	2,524	2,524	12
13	V								13
14	Total			$ 261,618			$ 239,456	$ * (22,162)	14

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	19	Management - Operating	$ 33,784	Tutera Helath Care Services	100.00%	$ 219,522	$ 185,738	15
16	V	30	Management - Depreciation		Tutera Helath Care Services	100.00%	7,402	7,402	16
17	V	22	Employement Expense	75	Walnut Creek Management Company LLC		75		17
18	V	20	Want Ads	93	Walnut Creek Management Company LLC		93		18
19	V	21	Postage & Small Equipment	2,316	Walnut Creek Management Company LLC		2,316		19
20	V	24	Seminar Expense	565	Walnut Creek Management Company LLC		565		20
21	V	26	Insurance	138,088	LTC Plus Insurance Inc		138,088		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			$ 174,921			$ 368,061	$ * 193,140	39

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Tutera	100%	Auburn Rehabilitation & helath Care Center	Auburn, IL	TI-Carlinville	Carlinville, IL	Building Company	1
2			Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Manage	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Se	Kansas City, MO	Management Co	3
4			Crystal Pines Rehabilitation & Health Care Cen	Crystal Lake, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Dixon Rehabilitation & Health Care Center	Dixon, IL	Walnut Creek - New E	Kansas City, MO	Management Co	5
6			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	Columbia 7611 LLC	Overland Park, KS	Building Company	6
7			Hamilton Memorial Rehabilitation & Health Ca	McLeansboro, IL	The Atriums Senior Li	Belton, MO	Independent/Assiste	7
8			Highland Rehabilitation & Health Care Center	Kansas City, MO	Carnegie Village Senio	Kansas/Missouri	Independent/Assiste	8
9			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Home Healtl	Kansas	Home Health	9
10			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice KS	Missouri	Hospice	10
11			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Continua Hospice MO	Muskogee, OK	Hospice	11
12			Meridian Rehabilitation & Health Care Center	Wichita, KS	Country Gardens Assi	Statesboro, GA	Assisted Living	12
13			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Gentilly Gardens Senic	Overland Park, KS	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care C	Independence, MO	Lamar Court Assisted	Freeport, IL	Assisted Living	14
15			Montgomery Children's Specialty Center	Montgomery, AL	Oakley Courts Assiste	Overland Park, KS	Assisted Living	15
16			Moweaqua Rehabilitation & Health Care Center	Moweaqua, IL	Rose Estates Assisted I	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons M	Kansas City, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Boiling Springs, SC	Independent/Assiste	18
19			Charlton Place Rehabilitation & Health Care Ce	Deatsville, AL	Wesley Court Assisted	Laurinburg, NC	Assisted Living	19
20			Stratford Commons Rehabilitation & Health Ca	Overland Park, KS	Willow Place Assisted Living & Memory Care (		Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Cai	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Cent	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 Rehabilitation & Health Care Cente	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 Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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, MO 64114
Phone Number: (816-444-0900
Fax Number: (816-822-0081

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Mangement Operating	Direct Costs	186,997,591	47	$ 10,144,719	$ 7,332,933	4,046,519	$ 219,526	1
2	30	Management Depreciation	Direct Costs	186,997,591	47	342,075		4,046,519	7,402	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					$ 10,486,794	$ 7,332,933		$ 226,928	25

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Tutera Investment		X				$	$ 266,008			$ 957	1
2	TI - Carlinville LLC - HUD		X	Mortgage				2,787,583			73,238	2
3	Interest Income										(1,220)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,053,591			$ 72,975	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 3,053,591			$ 72,975	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 12,471 Line # 36

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

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	39,415	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	39,765	2
3. Under or (over) accrual (line 2 minus line 1).	$	350	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,766	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	40,116	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	37,473	8
2012	38,313	9
2013	38,721	10
2014	39,415	11
2015	39,765	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlinville Rehab & HCC COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0049239

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

TELEPHONE 314-925-4446 FAX #: 314-925-4350

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 39,765.22	$ 39,765.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,765.22	$ 39,765.22

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 [ ] (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).

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	2,500	2008	$ 192,000	1
2					2
3	TOTALS	2,500		$ 192,000	3

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 1,968,000	$ 50,462	39	$ 50,462	$	$ 447,846	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	5,475	508	10	508		3,982	9
10	Various			2010	24,938	2,191	10	2,191		14,182	10
11	Backflow Preventer			2012	6,590	1,757	10	1,757		2,911	11
12	Main Roof Repair			2015	5,980	399	15	399		465	12
13	Asphalt Replacement			2015	11,900	298	40	298		496	13
14	Building Renovations (TI Carlinville)			2013	346,467	8,884	39	8,884		32,574	14
15	Roof Replacement (TI-Carlinville)			2016	56,480	3,295	10	3,295		3,295	15
16	Rooftop AC Unit (TI - Carlinville)			2016	6,000		15				16
17											17
18	HO Allocation					7,402		7,402			18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,431,830	$ 75,196		$ 75,196	$	$ 505,751	70

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 305,819	$ 10,766	$ 10,766	$	10	$ 289,669	71
72	Current Year Purchases	5,559	417	417		10	417	72
73	Fully Depreciated Assets	3,725					3,725	73
74								74
75	TOTALS	$ 315,103	$ 11,183	$ 11,183	$		$ 293,811	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 2,938,933	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,379	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,379	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 799,562	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 12,255 Description: Dishwasher, Laundry Machines, Plant & Copier (See WTB detail)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	$	10,079	$ 163,276	$ 559	10,079	$ 163,835	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		3,103	50,265	372	3,103	50,637	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		9,926	161,663		9,926	161,663	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				96,194		96,194	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB					32,305	81,897		114,202	13
14	TOTAL			$	23,108	$ 407,509	$ 179,022	23,108	$ 586,531	14

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

Facility Name & ID Number Carlinville Rehab & HCC **#** 0049239 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(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	$ 15,210	$ 27,875	1
2	Cash-Patient Deposits	24,173	27,723	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	800,763	800,763	3
4	Supply Inventory (priced at)	9,438	9,438	4
5	Short-Term Investments		145,860	5
6	Prepaid Insurance	142,046	154,909	6
7	Other Prepaid Expenses	86,268	86,268	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	14,936	51,909	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,092,834	$ 1,304,745	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		2,376,947	14
15	Leasehold Improvements, at Historical Cost	54,883	54,883	15
16	Equipment, at Historical Cost	52,672	315,103	16
17	Accumulated Depreciation (book methods)	(65,691)	(808,171)	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): Other Assets	7,872	60,379	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 49,736	$ 2,191,141	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,142,570	$ 3,495,886	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 220,802	$ 220,802	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,173	24,173	28
29	Short-Term Notes Payable	266,008	266,008	29
30	Accrued Salaries Payable	108,284	108,284	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,331	41,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)		39,765	32
33	Accrued Interest Payable		6,040	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident Deposits and Patient Refund	597	597	36
37	Other Accrued Expenses	757	757	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 661,952	$ 707,757	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,787,583	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)**	$	$ 2,787,583	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 661,952	$ 3,495,340	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 480,618	$ 546	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,142,570	$ 3,495,886	48

***(See instructions.)**

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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**	939,952	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,458,773	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(753)	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)**	$ (978,155)	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)**	$ 480,618	24 *

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 3,135,560	1
2	Discounts and Allowances for all Levels	(1,182,683)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,952,877	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,821,366	6
7	Oxygen	220,830	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,042,196	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,452	19
20	Radiology and X-Ray		20
21	Other Medical Services	45,646	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 63,098	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,220	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,220	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	40	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,059,431	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	691,971	31
32	Health Care	1,505,468	32
33	General Administration	783,457	33
	B. Capital Expense		
34	Ownership	278,864	34
	C. Ancillary Expense		
35	Special Cost Centers	621,871	35
36	Provider Participation Fee	178,553	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,060,184	40
41	**Income before Income Taxes (line 30 minus line 40)****	(753)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (753)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,099,390	44
45	Private Pay - Net Inpatient Revenue	571,699	45
46	Medicare - Net Inpatient Revenue	(546,135)	46
47	Other-(specify)	(172,077)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,952,877	49

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

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

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

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

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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	3,696	4,000	$ 129,974	$ 32.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,719	5,020	125,329	24.97	3
4	Licensed Practical Nurses	22,779	24,182	475,652	19.67	4
5	CNAs & Orderlies	39,770	41,050	519,845	12.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,761	5,035	58,901	11.70	10
11	Social Service Workers	1,778	1,918	55,953	29.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,964	2,119	27,859	13.15	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,872	2,000	56,755	28.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,140	5,392	78,771	14.61	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	991	1,062	11,252	10.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,470	91,778	$ 1,540,291 *	$ 16.78	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	$ 307,716	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,405	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	3,205	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 334,326		49

C. CONTRACT NURSES

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

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alisha R Heyen	Administrator	0	$ 47,222
Donna Dolliger	Administrator	0	9,533
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,755

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
Brown Hay & Stephans LLP	Legal Fee	$ 12,168
Heyl Royster Voelker & Allen	Legal Fee	525
Daniel Maher Law Offices	Legal Fee	200
Other - Legal Fee	Legal Fee	110
Frost/Marcum	Accounting Fee	9,169
PointClickCare Technologies Inc	Data Processing Fee	16,613
Tutera Health Care Services	Data Processing Fee	24,750
Kronos	Data Processing Fee	5,033
E-Health	Data Processing Fee	4,808
Pinnacle Quality Insight	Customer Satisfaction	1,662
Other - Data Processing Fee	Data Processing Fee	4,383
Various	Data Processing Fee	4,931
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 84,352

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,282
Unemployment Compensation Insurance	
FICA Taxes	153,845
Employee Health Insurance	49,964
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	5,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 248,541

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	4,136
Health Care Worker Background Check	
(Indicate # of checks performed 29)	292
Patient Background Checks	
Macoupin County Public Health Dept	110
IL Helathcare Association	6,468
Dues & Subscriptions	828
Other Licenses	351
Less: Public Relations Expense	(2,555)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,620

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,750
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,750

**See instructions.

Facility Name & ID Number Carlinville Rehab & HCC # 0049239 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 $6,468**

(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. $ **16,633** 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. $ **178,553**
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%**
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