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.

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: 0051870

Facility Name: Dixon Rehab & HCC

Address: 800 Division Street (Number) Dixon (City) 61021 (Zip Code)

County: Lee

Telephone Number: (815) 284-3393 **Fax #** (815) 284-2066

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2008

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 **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 1/01/2016 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) 925-4446 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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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 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	97	Skilled (SNF)	97	35,502	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	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,744	3,340	8,302	29,386	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,744	3,340	8,302	29,386	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.77%

D. How many bed-hold days during this year were paid by the Department?
0 (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 5/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 2,616

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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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		3,274	485,445	488,719		488,719		488,719			1
2	Food Purchase		29,808		29,808		29,808	(848)	28,960			2
3	Housekeeping		12,328	110,640	122,968		122,968		122,968			3
4	Laundry		9,603	73,760	83,363		83,363		83,363			4
5	Heat and Other Utilities			101,754	101,754		101,754		101,754			5
6	Maintenance	68,780	13,654	84,309	166,743		166,743		166,743			6
7	Other (specify):*											7
8	TOTAL General Services	68,780	68,667	855,908	993,355		993,355	(848)	992,507			8
	B. Health Care and Programs											
9	Medical Director					21,000	21,000		21,000			9
10	Nursing and Medical Records	1,804,025	94,928	25,686	1,924,639	(21,000)	1,903,639		1,903,639			10
10a	Therapy											10a
11	Activities	73,468	9,848	3,241	86,557		86,557		86,557			11
12	Social Services	27,031	38	3,317	30,386		30,386		30,386			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,904,524	104,814	32,244	2,041,582		2,041,582		2,041,582			16
	C. General Administration											
17	Administrative	109,889			109,889		109,889		109,889			17
18	Directors Fees											18
19	Professional Services			97,338	97,338		97,338	239,480	336,818			19
20	Dues, Fees, Subscriptions & Promotions			31,064	31,064		31,064	(3,437)	27,627			20
21	Clerical & General Office Expenses	92,386	23,568	652,954	768,908		768,908	(617,928)	150,980			21
22	Employee Benefits & Payroll Taxes			343,024	343,024		343,024		343,024			22
23	Inservice Training & Education					2,437	2,437		2,437			23
24	Travel and Seminar			6,135	6,135	(2,437)	3,698	(73)	3,625			24
25	Other Admin. Staff Transportation			6,150	6,150		6,150	(2,774)	3,376			25
26	Insurance-Prop.Liab.Malpractice			148,989	148,989		148,989		148,989			26
27	Other (specify):*											27
28	TOTAL General Administration	202,275	23,568	1,285,654	1,511,497		1,511,497	(384,732)	1,126,765			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,175,579	197,049	2,173,806	4,546,434		4,546,434	(385,580)	4,160,854			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 Dixon Rehab & HCC #0051870 Report Period Beginning: 1/01/2016 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,998	18,998		18,998	35,903	54,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,223	13,223		13,223	194,518	207,741			32
33	Real Estate Taxes			47,497	47,497		47,497		47,497			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			20,689	20,689		20,689		20,689			35
36	Other (specify):*											36
37	TOTAL Ownership			400,407	400,407		400,407	(69,579)	330,828			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200,341	500,994	701,335		701,335		701,335			39
40	Barber and Beauty Shops			40	40		40		40			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,572	214,572		214,572		214,572			42
43	Other (specify):* Marketing	31,937		21,891	53,828		53,828	(53,828)				43
44	TOTAL Special Cost Centers	31,937	200,341	737,497	969,775		969,775	(53,828)	915,947			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,207,516	397,390	3,311,710	5,916,616		5,916,616	(508,987)	5,407,629			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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	(1,649)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(10,383)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(202,886)	21		24
25	Fund Raising, Advertising and Promotional	(21,891)	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 See PG 5A	(39,474)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (276,283)		$	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)	(232,704)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (232,704)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (508,987)		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

Dixon Rehab & HCC

ID# 0051870

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Mileage	$ (2,774)	25	1
2	Vending Machine Revenue	(848)	02	2
3	Miscellaneous Income	(405)	21	3
4	Annual Report	(500)	20	4
5	PAC Dues	(2,937)	20	5
6	Marketing Salary	(31,937)	43	6
7	Marketing Seminars	(73)	24	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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**	(39,474)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	(848)	0	0	0	0	0	0	0	0	0	0	(848)	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(848)	0	0	0	0	0	0	0	0	0	0	(848)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	450	239,030	0	0	0	0	0	0	0	0	239,480	19
20	Fees, Subscriptions & Promotions	(3,437)	0	0	0	0	0	0	0	0	0	0	(3,437)	20
21	Clerical & General Office Expenses	(213,674)	0	(404,254)	0	0	0	0	0	0	0	0	(617,928)	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	(73)	0	0	0	0	0	0	0	0	0	0	(73)	24
25	Other Admin. Staff Transportation	(2,774)	0	0	0	0	0	0	0	0	0	0	(2,774)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(219,958)	450	(165,224)	0	0	0	0	0	0	0	0	(384,732)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(220,806)	450	(165,224)	0	0	0	0	0	0	0	0	(385,580)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dixon Rehab & HCC **#** 0051870 **Report Period Beginning:** 1/01/2016 **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	25,821	10,082	0	0	0	0	0	0	0	0	35,903	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,649)	196,167	0	0	0	0	0	0	0	0	0	194,518	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,649)	(78,012)	10,082	0	0	0	0	0	0	0	0	(69,579)	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):*	(53,828)	0	0	0	0	0	0	0	0	0	0	(53,828)	43
44	**TOTAL Special Cost Centers**	(53,828)	0	0	0	0	0	0	0	0	0	0	(53,828)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(276,283)	(77,562)	(155,142)	0	0	0	0	0	0	0	0	(508,987)	45

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	Rent	$ 300,000	TI - Dixon Illinois, LLC	100.00%	$	$ (300,000)	1
2	V	32	Interest		TI - Dixon Illinois, LLC	100.00%	196,167	196,167	2
3	V	19	Legal Fees		TI - Dixon Illinois, LLC	100.00%	450	450	3
4	V	30	Depreciation		TI - Dixon Illinois, LLC	100.00%	25,821	25,821	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 300,000			$ 222,438	$ * (77,562)	14

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

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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 & Health Care Center	Auburn, IL	TI- Dixon	Dixon, 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			Carlinville Rehabilitation & Health Care Center	Carlinville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Crystal Pines Rehabilitation & Health Care Cen	Crystal Lake, IL	Walnut Creek- New Er	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 Ca	McLeansboro, IL	The Atriums Senior Li	Overland Park, KS	Independent/Assiste	7
8			Highland Rehabilitation & Health Care Center	Kansas City, MO	Cunegie Village Senior	Belton, MO	Independent/Assiste	8
9			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Home Healtl	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 Assi	Muskogee, OK	Assisted Living	12
13			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Gentilly Gardens Senic	Statesboro, GA	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care C	Independence, MO	Lamar Court Assisted	Overland Park, KS	Assisted Living	14
15			Montgomery Children's Specialty Center	Montgomery, AL	Oakley Courts Assisted	Freeport, IL	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	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, MO	Independent/Assiste	18
19			Charlton Place Rehabilitation & Health Care Ce	Deatsville, AL	Wesley Court Assisted	Boiling Springs, SC	Assisted Living	19
20			Stratford Commons Rehabilitation & Health Ca	Overland Park, KS	Willow Place Assisted	Laurinburg, NC	Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Car	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 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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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. ☐ 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	21	Management Fees - Operating	$ 331,504	Tutera Health Care Services	100.00%	$	$ (331,504)	15
16	V	19	Management Fees - Operating	59,975	Tutera Health Care Services	100.00%	299,005	239,030	16
17	V	30	Management Fees - Depreciation		Tutera Health Care Services	100.00%	10,082	10,082	17
18	V	21	Postage & Delivery Services	8,752	Walnut Creek Management Company LLC		8,752		18
19	V	21	RP Asset Management Fees	72,750	JCT Capital LLC			(72,750)	19
20	V	26	Insurance	137,539	LTC Plus Insurance Inc.		137,539		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			$ 610,520			$ 455,378	$ * (155,142)	39

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

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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, 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	19	Management - Operating	Direct Cost	186,997,591	47	$ 10,144,719	$ 7,332,933	5,511,648	$ 299,010	1
2	30	Management - Capital	Direct Cost	186,997,591	47	342,075		5,511,648	10,082	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		$ 309,092	25

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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** 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	Note Payable - TI			$	$ 3,531,948			$ 13,223	1
2	TI Dixon Illinois, LLC		X	Note Payable - TI				3,387,528			196,167	2
3	Interest Income										(1,649)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,919,476			$ 207,741	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 6,919,476			$ 207,741	15

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

*** 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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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.**	$	45,114	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.)	$	45,924	2
3. Under or (over) accrual (line 2 minus line 1).	$	810	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,687	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.	$	47,497	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	43,728	8
	2012	44,244	9
	2013	45,538	10
	2014	45,088	11
	2015	45,924	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 Dixon Rehab & HCC COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051870

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen

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.	07-08-04-376-011	Long Term Care	$ 45,924.18	$ 45,924.18
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,924.18	$ 45,924.18

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? _____ 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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,700 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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	Facility	28,700	2002	$ 92,000	1
2					2
3	TOTALS	28,700		$ 92,000	3

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	97		2002	1973	$ 822,167	$ 25,821	33	$ 25,821	$	$ 606,501	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door Alarm System			2014	15,105	891	20	891		10,058	9
10	Generator Replacement			2014	30,599	5,875	20	5,875		21,786	10
11	Courtyard Concrete Sidewalk and Patio			2015	11,544	769	20	769		1,155	11
12	Commercial Flat Roof			2015	34,694	1,735	20	1,735		2,457	12
13	Repair to 300 Hall due to roof leaks - repairing drywall, ceiling, and paint			2015	6,809	454	20	454		454	13
14	Shower on 100 Hall was torn down to the studs, expanded, plumbing repla			2016	15,259	848	20	848		848	14
15	tile replaced, dry wall replaced, and paint										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	HO Depreciation Allocation					10,082		10,082			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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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)		$ 936,177	$ 46,475		$ 46,475	$	$ 643,259	70

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

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	$ 31,323	$ 7,557	$ 7,557	$		$ 22,179	71
72	Current Year Purchases	8,341	463	463			463	72
73	Fully Depreciated Assets	74,635					74,635	73
74								74
75	TOTALS	$ 114,299	$ 8,020	$ 8,020	$		$ 97,277	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		Ford Van	2012	$ 13,000	$ 406	$ 406	$	4	$ 13,000	76
77										77
78										78
79										79
80	TOTALS			$ 13,000	$ 406	$ 406	$		$ 13,000	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)	$ 1,155,476	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,901	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,901	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)	$ 753,536	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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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: $ 20,689 Description: Dish Machine, washers, copier (see WTB)
(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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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.

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	V39-3	hrs	$	2,959	$ 187,299	$	2,959	$ 187,299	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		1,024	61,668		1,024	61,668	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		3,446	216,557	504	3,446	217,061	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				135,246		135,246	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					35,470	64,591		100,061	13
14	TOTAL			$	7,429	$ 500,994	$ 200,341	7,429	$ 701,335	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 Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	$ 165,585	$ 275,361	1
2	Cash-Patient Deposits	39,273	39,273	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,414,982	1,414,982	3
4	Supply Inventory (priced at)	8,974	8,974	4
5	Short-Term Investments			5
6	Prepaid Insurance	145,532	145,532	6
7	Other Prepaid Expenses	89,885	89,885	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Workers Comp Prepaid	15,234	15,234	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,879,465	$ 1,989,241	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		92,000	13
14	Buildings, at Historical Cost		822,167	14
15	Leasehold Improvements, at Historical Cost	114,010	114,010	15
16	Equipment, at Historical Cost	52,664	127,299	16
17	Accumulated Depreciation (book methods)	(72,400)	(753,536)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,661	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,661)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other Long-Term Assets	29,839	29,839	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 124,113	$ 431,779	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,003,578	$ 2,421,020	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 259,429	$ 259,429	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,273	39,273	28
29	Short-Term Notes Payable	3,531,948	3,531,948	29
30	Accrued Salaries Payable	163,522	163,522	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,652	30,652	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,687	46,687	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WIP Claims	27,344	27,344	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,098,855	$ 4,098,855	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,387,528	39
40	Mortgage Payable			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)**	$	$ 3,387,528	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,098,855	$ 7,486,383	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,095,277)	$ (5,065,363)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,003,578	$ 2,421,020	48

***(See instructions.)**

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,706,471)	1
2	Restatements (describe):		2
3	CY Equity Reconciliation	2,125	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,704,346)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(390,931)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (390,931)	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)**	$ (2,095,277)	24 *

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

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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	$ 5,040,698	1
2	Discounts and Allowances for all Levels	(2,169,130)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,871,568	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,337,527	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,337,527	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(2,030)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	256,496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,332	19
20	Radiology and X-Ray		20
21	Other Medical Services	46,890	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 313,688	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,649	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,649	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending & Miscellaneous Income	1,253	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,253	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,525,685	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	993,355	31
32	Health Care	2,041,582	32
33	General Administration	1,511,497	33
	B. Capital Expense		
34	Ownership	400,407	34
	C. Ancillary Expense		
35	Special Cost Centers	755,203	35
36	Provider Participation Fee	214,572	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,916,616	40
41	**Income before Income Taxes (line 30 minus line 40)****	(390,931)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (390,931)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,957,481	44
45	Private Pay - Net Inpatient Revenue	563,619	45
46	Medicare - Net Inpatient Revenue	(444,230)	46
47	Other-(specify)	(205,302)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,871,568	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.**

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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	3,420	3,900	$ 127,738	$ 32.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,593	12,035	363,399	30.20	3
4	Licensed Practical Nurses	17,374	18,507	514,780	27.82	4
5	CNAs & Orderlies	56,705	58,785	808,378	13.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,116	6,299	73,468	11.66	10
11	Social Service Workers	1,833	1,881	27,031	14.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,779	3,177	68,780	21.65	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,968	2,000	93,543	46.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,664	8,000	86,961	10.87	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	819	1,087	11,501	10.58	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	1,459	1,617	31,937	19.75	33
34	TOTAL (lines 1 - 33)	111,730	117,288	$ 2,207,516 *	$ 18.82	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	$ 485,445	V01-3	35
36	Medical Director	Monthly	21,000	V9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,234	V10-3	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	3,241	V11-3	44
45	Social Service Consultant	Monthly	3,317	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 519,237		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Katheryn May	Administrator	0	$ 109,889
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,889

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
E-Health Data Solutions	Data Processing	$ 5,523
Tutera HC Services	Data Processing	13,174
Kronos	Workforce Mgmt Software	24,301
Marcum	Accounting	6,668
Pinnacle Quality Insights	Customer Satisfaction	2,184
Property Valuation Services	R/E Tax Assessment	100
DP	Data Processing	6,000
PointClickCare	Data Processing	20,918
CBO	Data Processing	16,500
Daniel Maher Law Offices	Legal	260
Allscripts	General Prof Svcs	1,710
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 97,338

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,717
Unemployment Compensation Insurance	
FICA Taxes	180,119
Employee Health Insurance	102,449
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	7,739
TOTAL (agree to Schedule V, line 22, col.8)	$ 343,024

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	18,576
Health Care Worker Background Check	
(Indicate # of checks performed 148)	1,484
Dues and Subsciptions	2,407
IL Health Care Association	6,257
Other Licenses	350
Less: Public Relations Expense	(3,437)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,627

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,625
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,625

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Dixon Rehab & HCC # 0051870 Report Period Beginning: 1/01/2016 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. **IL Health Care Association $6,257**

(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. $ **24,513** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **214,572**
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? **N/A** 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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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