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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053595

Facility Name: Moweaqua Rehabilitation & Health Care Center

Address: 525 South Macon St (Number) Moweaqua (City) 62550 (Zip Code)

County: Shelby

Telephone Number: 217-768-3951 **Fax #** 217-768-4971

HFS ID Number:

Date of Initial License for Current Owners: 6/01/2015

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 01/01/2017 to 12/31/2017 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) 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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	70	Skilled (SNF)	70	25,550	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	70	TOTALS	70	25,550	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	6,526	5,343	2,083	13,952	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,526	5,343	2,083	13,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.61%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Retirement (Independent Living)

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 [X] NO [ ]

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 6/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/01/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 1,580

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Cer # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	115,700	12,383	5,028	133,111		133,111		133,111			1
2	Food Purchase		86,119		86,119		86,119	(4,029)	82,090			2
3	Housekeeping	76,915	12,626	1,503	91,044		91,044		91,044			3
4	Laundry	24,296	16,082	100	40,478		40,478		40,478			4
5	Heat and Other Utilities			42,563	42,563		42,563		42,563			5
6	Maintenance	45,254	6,084	46,147	97,485		97,485		97,485			6
7	Other (specify):*											7
8	TOTAL General Services	262,165	133,294	95,341	490,800		490,800	(4,029)	486,771			8
	B. Health Care and Programs											
9	Medical Director					18,000	18,000		18,000			9
10	Nursing and Medical Records	895,007	52,448	97,662	1,045,117	(18,000)	1,027,117		1,027,117			10
10a	Therapy											10a
11	Activities	9,736	1,075	25,201	36,012		36,012		36,012			11
12	Social Services	35,229		4,463	39,692		39,692		39,692			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	939,972	53,523	127,326	1,120,821		1,120,821		1,120,821			16
	C. General Administration											
17	Administrative	91,081			91,081		91,081		91,081			17
18	Directors Fees											18
19	Professional Services			83,911	83,911		83,911	151,425	235,336			19
20	Dues, Fees, Subscriptions & Promotions			14,035	14,035		14,035	(1,801)	12,234			20
21	Clerical & General Office Expenses	62,194	15,669	317,830	395,693		395,693	(291,319)	104,374			21
22	Employee Benefits & Payroll Taxes			219,873	219,873		219,873	1,511	221,384			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,881	5,881		5,881	(180)	5,701			24
25	Other Admin. Staff Transportation			12,483	12,483		12,483	(2,981)	9,502			25
26	Insurance-Prop.Liab.Malpractice			122,810	122,810		122,810		122,810			26
27	Other (specify):*											27
28	TOTAL General Administration	153,275	15,669	776,823	945,767		945,767	(143,345)	802,422			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,355,412	202,486	999,490	2,557,388		2,557,388	(147,374)	2,410,014			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 Moweaqua Rehabilitation & Health Care Center #0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			43,888	43,888		43,888	106,350	150,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,097	20,097		20,097	16,071	36,168			32
33	Real Estate Taxes			94,901	94,901		94,901		94,901			33
34	Rent-Facility & Grounds			72,000	72,000		72,000	(72,000)				34
35	Rent-Equipment & Vehicles			6,597	6,597		6,597		6,597			35
36	Other (specify):* **Mortgage Ins**											36
37	**TOTAL Ownership**			237,483	237,483		237,483	50,421	287,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,174	299,661	433,835		433,835		433,835			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,848	113,848		113,848		113,848			42
43	Other (specify):* **Marketing & AL**	108,712		60,410	169,122		169,122	(169,122)				43
44	**TOTAL Special Cost Centers**	108,712	134,174	473,919	716,805		716,805	(169,122)	547,683			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,464,124	336,660	1,710,892	3,511,676		3,511,676	(266,075)	3,245,601			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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(3,595)	02		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	(13,491)	30		9
10	Interest and Other Investment Income	(25)	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	(9,419)	21		18
19	Entertainment	(4,579)	21		19
20	Contributions	(161)	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	(120,017)	21		24
25	Fund Raising, Advertising and Promotional	(20,515)	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	(154,242)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (326,044)		$	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)	59,969		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,969		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (266,075)		37

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

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

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

STATE OF ILLINOIS

Moweaqua Rehabilitation & Health Care Center

ID# 0053595

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Dues	$ (1,521)	20	1
2	PAC Dues	(280)	20	2
3	Marketing Mileage	(2,981)	25	3
4	Misc Income	(239)	21	4
5	Vending Machine Income	(434)	02	5
6	Marketing Salaries	(108,712)	43	6
7	Retirement Center Expenses	(39,895)	43	7
8	Marketing Seminar Expenses	(180)	24	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**	(154,242)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center **#** 0053595 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,029)	0	0	0	0	0	0	0	0	0	0	(4,029)	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**	(4,029)	0	0	0	0	0	0	0	0	0	0	(4,029)	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	250	151,175	0	0	0	0	0	0	0	0	151,425	19
20	Fees, Subscriptions & Promotions	(1,801)	0	0	0	0	0	0	0	0	0	0	(1,801)	20
21	Clerical & General Office Expenses	(134,415)	0	(156,904)	0	0	0	0	0	0	0	0	(291,319)	21
22	Employee Benefits & Payroll Taxes	0	1,511	0	0	0	0	0	0	0	0	0	1,511	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(180)	0	0	0	0	0	0	0	0	0	0	(180)	24
25	Other Admin. Staff Transportation	(2,981)	0	0	0	0	0	0	0	0	0	0	(2,981)	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**	(139,377)	1,761	(5,729)	0	0	0	0	0	0	0	0	(143,345)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(143,406)	1,761	(5,729)	0	0	0	0	0	0	0	0	(147,374)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center **#** 0053595 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(13,491)	114,572	5,269	0	0	0	0	0	0	0	0	106,350	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	16,096	0	0	0	0	0	0	0	0	0	16,071	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(72,000)	0	0	0	0	0	0	0	0	0	(72,000)	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**	(13,516)	58,668	5,269	0	0	0	0	0	0	0	0	50,421	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):*	(169,122)	0	0	0	0	0	0	0	0	0	0	(169,122)	43
44	**TOTAL Special Cost Centers**	(169,122)	0	0	0	0	0	0	0	0	0	0	(169,122)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(326,044)	60,429	(460)	0	0	0	0	0	0	0	0	(266,075)	45

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 PG6-Supp		See PG6-Supp		See PG6-Supp		

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	$ 72,000	JCTFLP-Moweaqua, LLC	100.00%	$	$ (72,000)	1
2	V	32	Interest		JCTFLP-Moweaqua, LLC	100.00%	16,096	16,096	2
3	V	19	Administrative		JCTFLP-Moweaqua, LLC	100.00%	250	250	3
4	V	22	Workers Comp		JCTFLP-Moweaqua, LLC	100.00%	1,511	1,511	4
5	V	30	Depreciation		JCTFLP-Moweaqua, LLC	100.00%	114,572	114,572	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			$ 72,000			$ 132,429	$ * 60,429	14

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

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	26	Insurance	$ 3,193	CarePlus Health Plans		$ 3,193	$	15
16	V	21	Management Fees	156,904	Tutera Health Care Services	100.00%		(156,904)	16
17	V	19	Management - Operating	41,528	Tutera Health Care Services	100.00%	192,703	151,175	17
18	V	30	Management - Depreciation		Tutera Health Care Services	100.00%	5,269	5,269	18
19	V	21	Small Equipment & Postage	3,747	Walnut Creek Management		3,747		19
20	V	25	Mileage Reimbursement	405	Auburn Nursing & Rehab		405		20
21	V	10	Nursing Staff & Medical Records	3,608	Auburn Nursing & Rehab		3,608		21
22	V	25	Mileage Reimbursement	984	Carlinville Rehab & Health Care		984		22
23	V	10	Nursing Staff & Medical Records	10,064	Carlinville Rehab & Health Care		10,064		23
24	V	06	Maintenance	1,187	Carlinville Rehab & Health Care		1,187		24
25	V	25	Mileage Reimbursement	372	Hamilton Memorial Nursing and Rehab		372		25
26	V	21	A&G Staff	762	Hillsboro Rehab & Healthcare Center		762		26
27	V	06	Maintenance	755	Hillsboro Rehab & Healthcare Center		755		27
28	V	25	Mileage Reimbursement	126	Lakeland Rehabilitation & Health		126		28
29	V	06	Maintenance	387	Lakeland Rehabilitation & Health		387		29
30	V	43	Advertising	45	Carlinville Rehab & Health Care		45		30
31	V	25	Mileage Reimbursement	410	Hillsboro Rehab & Healthcare Center		410		31
32	V	11	Activity Supplies	156	Walnut Creek Management		156		32
33	V	43	Advertising	2,018	Walnut Creek Management		2,018		33
34	V	20	Employee Want Ads	2,767	Walnut Creek Management		2,767		34
35	V	06	Maintenance Supplies	258	Walnut Creek Management		258		35
36	V	10	Nursing Supplies	48	Walnut Creek Management		48		36
37	V	26	Insurance	110,221	LTC Plus Insurance, Inc.		110,221		37
38	V								38
39	Total			$ 339,945			$ 339,485	$ * (460)	39

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

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	JCT Family Limited Partnership	99%	Auburn Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT Investments, LLC	1%	Windsor Rehab & Health Care Center	Terrell, TX	Carnegie Village Senio	Belton, MO	IL/AL	2
3			Bethany Rehab & Health Care Center	DeKalb, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Carlinville Rehab & Health Care Center	Carlinville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Coulterville Rehab & Health Care Center	Coulterville, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Dixon Rehab & Health Care Center	Dixon, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Hamilton Memorial Rehab & HC Center	McLeansboro, IL	Victory Hills Senior Li	Kansas City, KS	IL/AL	9
10			Highland Rehab & Health Care Center	Kansas City, MO	Wesley Court Assisted	Boiling Springs, SC	AL	10
11			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Willow Place Asst. Liv	Laurinburg, NC	AL	11
12			Lakeland Rehab & Health Care Center	Effingham, IL	Bright Oaks of Aurora	Aurora, IL	AL	12
13			Mattoon Rehab & Health Care Center	Mattoon, IL	Paradise Park Assisted	Fox Lake, IL	AL	13
14			Meridian Rehab & Health Care Center	Wichita, KS	JCT FLP - Moweaqua	Moweaqua, IL	Building Company	14
15			Metropolis Rehab & Health Care Center	Metropolis, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	15
16			Monterey Park Rehab & Health Care Center	Independence, MO	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Montgomery Children's Specialty Center	Montgomery, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Charlton Place Rehab & HC Center	Deatsville, AL	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Westridge Gardens Rehab & HC Center	Raytown, MO	Walnut Creek New En	Kansas City, MO	Mgmt Company	19
20			Willow Care Rehab & Health Care Center	Hannibal, MO	Tutera Investments, In	Kansas City, MO	Mgmt Company	20
21			Holly Hill Rehab & Health Care Center	Sulphur, LA	JCT Capital LLC	Kansas City, MO	Mgmt Company	21
22			Rosewood Rehab & Health Care Center	Lake Charles, LA	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Beautiful Savior Rehab & HC Center	Belton, MO	LTC Plus Insurance In	Kansas City, MO	Insurance Company	23
24			Greenfield Manor	Greenfield, IA				24
25			Griswold Care Center	Griswold, IA				25
26			Stratford Rehab & Health Care Center	Overland Park, KS				26
27			Carnegie Village Rehabilitation & Health Care C	Belton, MO				27
28			Tiffany Springs Rehabilitation & Health Care C	Kansas City, MO				28
29								29
30								30

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Ce # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 Fee - Operating	Direct Costs	168,868,621	42	$ 9,661,251	$ 7,250,104	3,368,226	$ 192,702	1
2	30	Management Fee - Depreciation	Direct Costs	168,868,621	42	264,186		3,368,226	5,269	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					$ 9,925,437	$ 7,250,104		$ 197,971	25

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Cer # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Tutera Investments LLC	X		Note Payable			$ 2,696,000	$		0.0075	$ 9,549	1
2	JCT Capital	X		Note Payable			4,337,988	4,652,647		0.0100	26,644	2
3	Interest Income Offset										(25)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 7,033,988	$ 4,652,647			$ 36,168	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,033,988	$ 4,652,647			$ 36,168	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 94,900	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.)		$ 95,851	2
3. Under or (over) accrual (line 2 minus line 1).		$ 951	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,950	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.		$ 94,901	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	92,285	8
	2013	90,111	9
	2014	90,646	10
	2015	94,901	11
	2016	95,851	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Moweaqua Rehabilitation & Health Care Center COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0053595

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1001-31-00-200-011	Long-Term Care	$ 95,850.94	$ 95,850.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 95,850.94	$ 95,850.94

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000 B. General Construction Type: Exterior Brick Frame Steel 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).

The facility maintains a 20-bed wing for retirement residents not requiring skilled or intermediate care.

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	26,000	2015	$ 185,364	1
2					2
3	TOTALS	26,000		$ 185,364	3

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	70		2015	2015	$ 1,760,958	$ 44,024	40	$ 44,024	$	$ 99,054	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT ASPHALT			2016	7,500	188	7	188		281	9
10	14 AIR CONDITIONERS			2016	13,986	932	15	932		1,476	10
11	SIGNAGE-INDOOR			2016	7,566		15			126	11
12	LOBBY FLOORING			2016	122,540	8,169	15	8,169		10,212	12
13	NURSE STATION CEILING			2016	12,174	812	15	812		1,015	13
14	INTERIOR DOORS			2016	21,738	1,449	15	1,449		1,811	14
15	3 WATER HEATERS			2017	15,489	639	10	639		639	15
16											16
17	HOME OFFICE DEPRECIATION					5,269		5,269			17
18											18
19	SPRINKLER LINE REPLACEMENTS (JCTFLP-MOWEAQUA)			2015	23,170	2,317	10	2,317		5,213	19
20	SPRINKLER PIPING (JCTFLP-MOWEAQUA)			2015	20,450	818	25	818		1,841	20
21	WIRING FOR INTERNET SERVICES (JCTFLP-MOWEAQUA)			2015	11,080	2,216	5	2,216		5,170	21
22	VINYL TILE AND COVERBASE - ALL HALLS (JCTFLP-MOWEAQU			2015	6,015	601	10	601		1,353	22
23	SPA ROOM REMODEL (JCTFLP-MOWEAQUA)			2016	22,126	1,475	15	1,475		1,844	23
24	SHOWER ROOM REMODEL (JCTFLP-MOWEAQUA)			2016	26,571	1,771	15	1,771		2,214	24
25	LOTUS PRIVATE SHOWER REMODEL (JCTFLP-MOWEAQUA)			2016	69,463	4,633	15	4,633		5,789	25
26	PHYSICAL THERAPY ROOMS REMODEL (JCTFLP-MOWEAQUA)			2016	9,469	631	15	631		789	26
27	LOTUS LIVING, DINING ROOMS REMODEL (JCTFLP-MOWEAQU			2016	53,413	3,561	15	3,561		4,451	27
28	RECEPTION REMODEL (JCTFLP-MOWEAQUA)			2016	6,096	406	15	406		508	28
29	WALL SCONCE & LIGHTING UPGRADES-HALL (JCTFLP-MOWEA			2016	12,037	802	15	802		1,003	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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 433,910	$ 60,880	$ 60,880	$	Various	$ 129,745	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 433,910	$ 60,880	$ 60,880	$		$ 129,745	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		2009 FORD STARTRANS	2015	$ 43,227	$ 8,645	$ 8,645	$	5	$ 20,173	76
77										77
78										78
79										79
80	TOTALS			$ 43,227	$ 8,645	$ 8,645	$		$ 20,173	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)	$ 2,884,342	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 150,238	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,238	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)	$ 294,707	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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 6,597 Description: 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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-3	hrs	$	1,578	$ 114,706	$	1,578	$ 114,706	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		473	30,723		473	30,723	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		1,547	110,043	270	1,547	110,313	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				63,520		63,520	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					44,189	70,384		114,573	13
14	TOTAL			$	3,598	$ 299,661	$ 134,174	3,598	$ 433,835	14

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

STATE OF ILLINOIS

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 236,049	$ 246,140	1
2	Cash-Patient Deposits	5,561	5,561	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	403,176	403,176	3
4	Supply Inventory (priced at)	14,359	14,359	4
5	Short-Term Investments			5
6	Prepaid Insurance	98,597	98,597	6
7	Other Prepaid Expenses	12,139	12,139	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	2,670	2,670	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 772,551	$ 782,642	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		185,364	13
14	Buildings, at Historical Cost	193,493	2,191,171	14
15	Leasehold Improvements, at Historical Cost	7,500	30,670	15
16	Equipment, at Historical Cost	112,920	477,137	16
17	Accumulated Depreciation (book methods)	(50,153)	(294,707)	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 Long-Term Assets	(57,397)	(1,712,214)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 206,363	$ 877,421	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 978,914	$ 1,660,063	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 327,917	$ 327,917	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,561	5,561	28
29	Short-Term Notes Payable	2,711,107	2,711,107	29
30	Accrued Salaries Payable	68,083	68,083	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,055	40,055	31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,951	93,951	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	14,082	418,249	36
37	Medicaid Settlement		79,006	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,260,756	$ 3,743,929	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,941,540	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)**	$	$ 1,941,540	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,260,756	$ 5,685,469	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,281,842)	$ (4,025,406)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 978,914	$ 1,660,063	48

***(See instructions.)**

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,324,545)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,324,545)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(798,371)	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	(158,926)	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)**	$ (957,297)	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)**	$ (2,281,842)	24 *

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

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 2,247,358	1
2	Discounts and Allowances for all Levels	(1,237,798)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,009,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,432,506	6
7	Oxygen	208	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,432,714	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	3,595	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	168,046	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,335	19
20	Radiology and X-Ray		20
21	Other Medical Services	84,357	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 270,333	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Revenue	434	28
28a	Misc Income	239	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 673	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,713,305	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	490,800	31
32	Health Care	1,120,821	32
33	General Administration	945,767	33
	B. Capital Expense		
34	Ownership	237,483	34
	C. Ancillary Expense		
35	Special Cost Centers	602,957	35
36	Provider Participation Fee	113,848	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,511,676	40
41	**Income before Income Taxes (line 30 minus line 40)****	(798,371)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (798,371)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 909,330	44
45	Private Pay - Net Inpatient Revenue	787,025	45
46	Medicare - Net Inpatient Revenue	(583,483)	46
47	Other-(specify) Insurance	(103,312)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,009,560	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.**

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	3,024	3,314	$ 100,664	$ 30.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,265	4,337	124,240	28.65	3
4	Licensed Practical Nurses	9,919	10,551	242,371	22.97	4
5	CNAs & Orderlies	30,859	31,762	427,732	13.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,050	1,086	9,736	8.97	10
11	Social Service Workers	1,588	1,969	35,229	17.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,639	11,123	115,700	10.40	15
16	Dishwashers					16
17	Maintenance Workers	2,374	2,462	45,254	18.38	17
18	Housekeepers	6,759	7,231	76,915	10.64	18
19	Laundry	2,655	2,815	24,296	8.63	19
20	Administrator	2,128	2,170	91,081	41.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,981	4,327	62,194	14.37	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					31
32	Other Health Care(specify)			0		32
33	Other(specify) Marketing/ALF	8,333	8,913	108,712	12.20	33
34	TOTAL (lines 1 - 33)	87,574	92,060	$ 1,464,124 *	$ 15.90	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	$ 5,028	V01-3	35
36	Medical Director	Monthly	18,000	V09-5	36
37	Medical Records Consultant	Monthly	541	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,965	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	21,907	V11-3	44
45	Social Service Consultant	Monthly	4,463	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 53,904		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	477	$ 16,692	V10-3	50
51	Licensed Practical Nurses	122	4,950	V10-3	51
52	Certified Nurse Assistants/Aides	109	3,283	V10-3	52
53	TOTAL (lines 50 - 52)	708	$ 24,925		53

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashley Blevins	Administrator	0	$ 6,923
Tom Mullins	Administrator	0	5,885
Harry Poole	Administrator	0	6,923
Cheryl Vittorio	Administrator	0	19,408
Stephanie Williams	Administrator	0	15,385
Tom Stephenson	Administrator	0	36,557
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 91,081

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Offices	Legal	$ 3,260
Forte LLC	Legal	140
CliftonLarsonAllen LLP	Accounting/Cost Report	3,680
Walnut Creek Mgmt Co, LLC	Data Processing	41,529
Ability Network Inc	Data Processing	3,590
PointClickCare Technologies	Data Processing	20,530
Allscripts Healthcare LLC	Professional Services	1,330
Curaspan Health Group	Professional Services	7,500
Pinnacle Quality Insight	Professional Services	2,252
Property Valuation Services	Professional Services	100
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 83,911

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,584
Unemployment Compensation Insurance	
FICA Taxes	139,494
Employee Health Insurance	28,264
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	14,042
TOTAL (agree to Schedule V, line 22, col.8)	$ 221,384

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,320
Advertising: Employee Recruitment	4,818
Health Care Worker Background Check	
(Indicate # of checks performed 90)	906
Patient Background Checks	
IL Health Care Association	5,061
IHCA PAC	280
CLIA Laboratory Program	150
IL Secretary of State	250
Shelby County Health Department	250
Less: Public Relations Expense	(1,801)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,234

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,881
Marketing	(180)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,701

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Moweaqua Rehabilitation & Health Care Center # 0053595 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 $5,061**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,187** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **113,848**
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? **Yes** 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? **Yes** Indicate the amount. $ **3,595**

(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? **No**
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? **Yes**
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