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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0051870

Facility Name: Dixon Healthcare & Rehab Ctr

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: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/13 to 12/31/13 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) Steven N. Lavenda, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	35,405	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	35,405	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	18,279	4,939	5,614	28,832	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,279	4,939	5,614	28,832	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.43%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 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 4,059

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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		7,262	489,340	496,602		496,602		496,602			1
2	Food Purchase		12,825		12,825		12,825	(715)	12,110			2
3	Housekeeping		9,622	116,866	126,488		126,488		126,488			3
4	Laundry		6,418	75,704	82,122		82,122		82,122			4
5	Heat and Other Utilities			87,470	87,470		87,470	1,875	89,345			5
6	Maintenance	70,816	7,542	70,745	149,103		149,103	(8,364)	140,739			6
7	Other (specify):*											7
8	**TOTAL General Services**	70,816	43,669	840,125	954,610		954,610	(7,204)	947,406			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,703,413	116,804	6,131	1,826,348		1,826,348	55,523	1,881,871			10
10a	Therapy											10a
11	Activities	79,245	6,594	4,030	89,869		89,869		89,869			11
12	Social Services	84,513		3,286	87,799		87,799		87,799			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,731	5,731			15
16	**TOTAL Health Care and Programs**	1,867,171	123,398	25,447	2,016,016		2,016,016	61,254	2,077,270			16
	C. General Administration											
17	Administrative	60,202		340,997	401,199		401,199	(338,071)	63,128			17
18	Directors Fees											18
19	Professional Services			33,604	33,604	(100)	33,504	1,842	35,346			19
20	Dues, Fees, Subscriptions & Promotions			114,533	114,533		114,533	(30,396)	84,137			20
21	Clerical & General Office Expenses	117,560	25,757	260,454	403,771		403,771	(35,904)	367,867			21
22	Employee Benefits & Payroll Taxes			441,693	441,693		441,693		441,693			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,540	4,540		4,540	(657)	3,883			24
25	Other Admin. Staff Transportation			25,507	25,507		25,507	27,159	52,666			25
26	Insurance-Prop.Liab.Malpractice			107,637	107,637		107,637	1,107	108,744			26
27	Other (specify):*							28,503	28,503			27
28	**TOTAL General Administration**	177,762	25,757	1,328,965	1,532,484	(100)	1,532,384	(346,417)	1,185,967			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,115,749	192,824	2,194,537	4,503,110	(100)	4,503,010	(292,367)	4,210,643			29

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

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 Healthcare & Rehab Ctr #0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			12,323	12,323		12,323	26,937	39,260			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,549	5,549		5,549	168,533	174,082			32
33	Real Estate Taxes			44,556	44,556	100	44,656	1,052	45,708			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)	(0)			34
35	Rent-Equipment & Vehicles			10,445	10,445		10,445	628	11,073			35
36	Other (specify):*											36
37	**TOTAL Ownership**			372,873	372,873	100	372,973	(102,851)	270,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,003	607,472	766,475		766,475		766,475			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,059	201,059		201,059		201,059			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		159,003	808,531	967,534		967,534		967,534			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,115,749	351,827	3,375,941	5,843,517		5,843,517	(395,219)	5,448,298			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(348)	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	(5,942)	30		9
10	Interest and Other Investment Income	(28,938)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,391)	21		18
19	Entertainment	(6,790)	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	(178,182)	21		24
25	Fund Raising, Advertising and Promotional	(27,100)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,043)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (273,755)		$	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)	(121,463)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (121,463)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (395,219)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Dixon Healthcare & Rehab Ctr

ID# 0051870

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (345)	02	1
2	Annual Reports	(250)	20	2
3	Capitalized R&M	(13,501)	06	3
4	Non-Allowable Legal	(305)	19	4
5	Non-Allowable Seminars	(3,965)	24	5
6	Miscellaneous Income	(540)	21	6
7	IHCA Dues	(3,686)	20	7
8	Building Company - Legal Fees	(450)	19	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**	(23,043)		49

Dixon Healthcare & Rehab Ctr

ID# 0051870

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(715)											(715)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,875								1,875	5
6	Maintenance	(13,501)		3,755	1,382								(8,364)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(14,216)		3,755	3,257								(7,204)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			55,523									55,523	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,731									5,731	15
16	**TOTAL Health Care and Programs**			61,254									61,254	16
	C. General Administration													
17	Administrative			(338,071)									(338,071)	17
18	Directors Fees													18
19	Professional Services	(755)	450	2,109	38								1,842	19
20	Fees, Subscriptions & Promotions	(31,036)		640									(30,396)	20
21	Clerical & General Office Expenses	(188,903)		152,990	9								(35,904)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,965)		3,308									(657)	24
25	Other Admin. Staff Transportation			27,159									27,159	25
26	Insurance-Prop.Liab.Malpractice			1,026	81								1,107	26
27	Other (specify):*			28,503									28,503	27
28	**TOTAL General Administration**	(224,660)	450	(122,335)	128								(346,417)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(238,876)	450	(57,326)	3,385								(292,367)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Dixon Healthcare & Rehab Ctr **#** 0051870 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(5,942)	29,954	1,662	1,263								26,937	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(28,938)	195,631	314	1,526								168,533	32
33	Real Estate Taxes			106	946								1,052	33
34	Rent-Facility & Grounds		(300,000)	8,641	(8,641)								(300,000)	34
35	Rent-Equipment & Vehicles			628									628	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(34,880)	(74,415)	11,350	(4,907)								(102,851)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(273,755)	(73,965)	(45,976)	(1,522)								(395,219)	45

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 LLC	100.00%	$	$ (300,000)	1
2	V	32	Interest		TI - Dixon LLC	100.00%	195,631	195,631	2
3	V	19	Legal Fees		TI - Dixon LLC	100.00%	450	450	3
4	V	30	Depreciation		TI - Dixon LLC	100.00%	29,954	29,954	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			$ 226,035	$ * (73,965)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	6	REPAIRS, MAINTENANCE & SECUR	$	Tutera Health Care Services	100.00%	$ 3,755	$ 3,755	15
16	V	10	NURSING & MEDICAL RECORDS		Tutera Health Care Services	100.00%	238	238	16
17	V	10	NURSING SALARIES		Tutera Health Care Services	100.00%	55,285	55,285	17
18	V	15	NURSING TAXES & BENEFITS		Tutera Health Care Services	100.00%	5,731	5,731	18
19	V	17	OWNER SALARY- JOE TUTERA		Tutera Health Care Services	100.00%	2,926	2,926	19
20	V	19	PROFESSIONAL FEES		Tutera Health Care Services	100.00%	2,109	2,109	20
21	V	20	DUES, FEES, LICENSES, MEMBERSHIPS		Tutera Health Care Services	100.00%	640	640	21
22	V	21	OFFICE EXPENSES		Tutera Health Care Services	100.00%	13,241	13,241	22
23	V	21	OFFICE SALARIES		Tutera Health Care Services	100.00%	139,749	139,749	23
24	V	24	BUSINESS SEMINAR		Tutera Health Care Services	100.00%	3,308	3,308	24
25	V	25	TRAVEL EXPENSES		Tutera Health Care Services	100.00%	27,159	27,159	25
26	V	26	INSURANCE		Tutera Health Care Services	100.00%	1,026	1,026	26
27	V	27	EMP BENEFITS & PAYROLL TAXES		Tutera Health Care Services	100.00%	28,503	28,503	27
28	V	30	DEPRECIATION		Tutera Health Care Services	100.00%	1,662	1,662	28
29	V	32	INTEREST EXPENSE		Tutera Health Care Services	100.00%	314	314	29
30	V	33	REAL ESTATE TAXES		Tutera Health Care Services	100.00%	106	106	30
31	V	34	RENTAL OF SPACE		Tutera Health Care Services	100.00%	8,641	8,641	31
32	V	35	EQUIPMENT RENTAL		Tutera Health Care Services	100.00%	121	121	32
33	V	35	AUTO RENTAL		Tutera Health Care Services	100.00%	506	506	33
34	V								34
35	V	17	MANAGEMENT FEES	340,997	Tutera Health Care Services	100.00%		(340,997)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 340,997			$ 295,021	$ * (45,976)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	Columbia 7611, LLC	100.00%	$ 1,875	$ 1,875	15
16	V	6	REPAIRS, MAINTENANCE & SECURITY		Columbia 7611, LLC	100.00%	1,382	1,382	16
17	V	19	PROFESSIONAL FEES		Columbia 7611, LLC	100.00%	38	38	17
18	V	21	OFFICE EXPENSES		Columbia 7611, LLC	100.00%	9	9	18
19	V	26	INSURANCE		Columbia 7611, LLC	100.00%	81	81	19
20	V	30	DEPRECIATION		Columbia 7611, LLC	100.00%	1,263	1,263	20
21	V	32	INTEREST EXPENSE		Columbia 7611, LLC	100.00%	1,526	1,526	21
22	V	33	REAL ESTATE TAXES		Columbia 7611, LLC	100.00%	946	946	22
23	V								23
24	V	34	RENT	8,641	Columbia 7611, LLC	100.00%		(8,641)	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			$ 8,641			$ 7,119	$ * (1,522)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Management Compa	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Services, LLC	Kansas City, MO	Management Co	3
4			Carlinville Rehabilitation & Health Care Center	Carlinville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Crystal Pines Rehabilitation & Health Care Center	Crystal Lake, IL	Walnut Creek- New England, LLC	Kansas City, MO	Management Co	5
6			Dixon Rehabilitation & Health Care Center	Dixon, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	6
7			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	The Atriums Senior Living Commu	Overland Park, KS	Independent/Assisted Living	7
8			Hamilton Memorial Rehabilitation & Health Care Center	McLeansboro, IL	Carnegie Village Senior Living Con	Belton, MO	Independent/Assisted Living	8
9			Highland Rehabilitation & Health Care Center	Kansas City, MO	Continua Home Health	Kansas/Missouri	Home Health	9
10			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Hospice KS	Kansas	Hospice	10
11			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice MO	Missouri	Hospice	11
12			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Country Gardens Assisted Living C	Muskogee, OK	Assisted Living	12
13			Meridian Rehabilitation & Health Care Center	Wichita, KS	Gentilly Gardens Senior Living Cor	Statesboro, GA	Assisted Living	13
14			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Lamar Court Assisted Living Comm	Overland Park, KS	Assisted Living	14
15			Monterey Park Rehabilitation & Health Care Center	Independence, MO	Oakley Courts Assisted Living Con	Freeport, IL	Assisted Living	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Rose Estates Assisted Living Comm	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons Memory Care	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Living Commu	Kansas City, KS	Independent/Assisted Living	18
19			Charlton Place Rehabilitation & Health Care Center	Deatsville, AL	Wesley Court Assisted Living Com	Boiling Springs, SC	Assisted Living	19
20			Westridge Gardens Rehabilitation & Health Care Center	Raytown, MO	Willow Place Assisted Living & Me	Laurinburg, NC	Assisted Living	20
21			Willow Care Rehabilitation & Health Care Center	Hannibal, MO				21
22			Holly Hill House	Sulphur, LA				22
23			Rosewood Nursing Center	Lake Charles, LA				23
24			Beautiful Savior	Belton, MO				24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Joseph Tutera	Owner	Administrative	100%	See Attached	2.00	3.33%	Alloc. Sal.	$ 2,926	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 2,926		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	6	REPAIRS, MAINTENANCE & S	PATIENT DAYS	704,115	24	$ 91,797	$	28,801	$ 3,755	1
2	10	NURSING & MEDICAL RECOR	PATIENT DAYS	704,115	24	5,822		28,801	238	2
3	10	NURSING SALARIES	PATIENT DAYS	704,115	24	1,351,593	1,351,593	28,801	55,285	3
4	15	NURSING TAXES & BENEFITS	PATIENT DAYS	704,115	24	140,104		28,801	5,731	4
5	17	OWNER SALARY- JOE TUTER	PATIENT DAYS	704,115	24	71,528	71,528	28,801	2,926	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	704,115	24	51,570		28,801	2,109	6
7	20	DUES, FEES, LICENSES, MEMI	PATIENT DAYS	704,115	24	15,649		28,801	640	7
8	21	OFFICE EXPENSES	PATIENT DAYS	704,115	24	323,707		28,801	13,241	8
9	21	OFFICE SALARIES	PATIENT DAYS	704,115	24	3,416,537	3,416,537	28,801	139,749	9
10	24	BUSINESS SEMINAR	PATIENT DAYS	704,115	24	80,864		28,801	3,308	10
11	25	TRAVEL EXPENSES	PATIENT DAYS	704,115	24	663,971		28,801	27,159	11
12	26	INSURANCE	PATIENT DAYS	704,115	24	25,084		28,801	1,026	12
13	27	EMP BENEFITS & PAYROLL T	PATIENT DAYS	704,115	24	696,836		28,801	28,503	13
14	30	DEPRECIATION	PATIENT DAYS	704,115	24	40,633		28,801	1,662	14
15	32	INTEREST EXPENSE	PATIENT DAYS	704,115	24	7,671		28,801	314	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	704,115	24	2,590		28,801	106	16
17	34	RENTAL OF SPACE	PATIENT DAYS	704,115	24	211,243		28,801	8,641	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	704,115	24	2,964		28,801	121	18
19	35	AUTO RENTAL	PATIENT DAYS	704,115	24	12,377		28,801	506	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,212,541	$ 4,839,657		$ 295,021	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	704,115	24	$ 45,827	$	28,801	$ 1,875	1
2	6	REPAIRS, MAINTENANCE & S	PATIENT DAYS	704,115	24	33,791		28,801	1,382	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	704,115	24	925		28,801	38	3
4	21	OFFICE EXPENSES	PATIENT DAYS	704,115	24	225		28,801	9	4
5	26	INSURANCE	PATIENT DAYS	704,115	24	1,976		28,801	81	5
6	30	DEPRECIATION	PATIENT DAYS	704,115	24	30,872		28,801	1,263	6
7	32	INTEREST EXPENSE	PATIENT DAYS	704,115	24	37,300		28,801	1,526	7
8	33	REAL ESTATE TAXES	PATIENT DAYS	704,115	24	23,127		28,801	946	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					$ 174,043	$		$ 7,119	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			$	$ 1,420,997			$ 5,549	1
2	TI - Dixon		X	Note Payable - TGI				3,195,100			195,631	2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Tutera HC Services		X								314	6
7	Allocated from Columbia 7611		X								1,526	7
8												8
9	TOTAL Facility Related						$	$ 4,616,096			$ 203,020	9
	B. Non-Facility Related*											
10	Interest Income		X								(28,938)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (28,938)	14
15	TOTALS (line 9+line14)						$	$ 4,616,096			$ 174,082	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 44,400	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.)		$ 45,296	2
3. Under or (over) accrual (line 2 minus line 1).		$ 896	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 44,713	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 100	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 45,709	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011	43,728	11
2012	44,244	12

2013 Accrual: $44,244 x 1.01 = $44,713

Allocated from Tutera Health Care Services: $106

Allocated from Columbia 7611 LLC: $946

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dixon Healthcare & Rehab Ctr COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051870

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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	$ 44,243.64	$ 44,243.64
2.	See Attached	See Attached	$ 69,694.64	$ 945.97
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 113,938.28	$ 45,189.61

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Dixon Healthcare & Rehab Ctr COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051870

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 92,000	1
2	Allocated from Columbia 7611 LLC			3,868	2
3	TOTALS			$ 95,868	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 983,365	$ 29,954	Various	$ 29,954	$	$ 521,633	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		41,856	1,395		1,360	(35)	29,222	68
69	Financial Statement Depreciation			12,323			(12,323)		69
70	TOTAL (lines 4 thru 69)		$ 1,025,221	$ 43,672		$ 31,314	$ (12,358)	$ 550,855	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,025,221	$ 43,672		$ 31,314	$ (12,358)	$ 550,855	1
2	5 Ton Ac Unit	2012	6,839		20	342	342	3,932	2
3	Hot Water Heater	2013	7,085		20	354	354	354	3
4	Blinds; Wood Blinds	2013	3,568		20	178	178	178	4
5	Vinyl Flooring In Shower Room	2013	3,012		20	151	151	151	5
6	Power Generator Repairs	2013	3,850		20	193	193	193	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	1
2									2
3									3
4									4
5									5
6									6
7									7
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,049,575	$ 43,672		$ 32,532	$ (11,140)	$ 555,663	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Columbia 7611 LLC	1989	33,447	1,061	20	956	(105)	23,891	3
4	Allocated from Columbia 7611 LLC	1990	3,827	121	20	109	(12)	2,624	4
5	Allocated from Columbia 7611 LLC	1991	506	16	20	14	(2)	332	5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Walnut Creek Management Company	2006	1,700	127	20	85	(42)	680	9
10	Allocated from Walnut Creek Management Company	2007	41	6	20	81	75	567	10
11									11
12	Allocated from LTC Services LLC	2001	69		20	3	3	45	12
13	Allocated from LTC Services LLC	2002	64		20	3	3	38	13
14									14
15	Allocated from Columbia 7611 LLC	1989	18		20			18	15
16	Allocated from Columbia 7611 LLC	1994	95	2	20	5	3	95	16
17	Allocated from Columbia 7611 LLC	1995	147	4	20	7	3	140	17
18	Allocated from Columbia 7611 LLC	1996	274	4	20	14	10	247	18
19	Allocated from Columbia 7611 LLC	2003	106	3	20	5	2	59	19
20	Allocated from Columbia 7611 LLC	2006	518	23	20	26	3	207	20
21	Allocated from Columbia 7611 LLC	2008	817	22	20	41	19	245	21
22	Allocated from Columbia 7611 LLC	2011	227	6	20	11	5	34	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 41,856	$ 1,395		$ 1,360	$ (35)	$ 29,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 11,786	$ 641	$ 1,179	$ 538	10	$ 7,324	71
72	Current Year Purchases	20,984	403	2,098	1,695	10	2,098	72
73	Fully Depreciated Assets	85,015		185	185	10	85,015	73
74								74
75	TOTALS	$ 117,785	$ 1,044	$ 3,462	$ 2,418		$ 94,437	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	$	$ 2,600	$ 2,600	5	$ 10,319	76
77		Allocated from Walnut Creek Ma	2013	4,318	484	664	180	5	3,710	77
78		Allocated from LTC Services	2013	1,608				5	1,608	78
79										79
80	TOTALS			$ 18,926	$ 484	$ 3,264	$ 2,780		$ 15,637	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)	$	1,282,154	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	45,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	39,258	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(5,942)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	665,737	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 10,567 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Tutera HC Services		$	$ 506	17
18					18
19					19
20					20
21	TOTAL		$	$ 506	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 225,604	$		$ 225,604	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			96,036			96,036	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			250,514			250,514	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				110,124		110,124	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					35,318	48,879		84,197	13
14	TOTAL			$		$ 607,472	$ 159,003		$ 766,475	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 101,925	$ 221,854	1
2	Cash-Patient Deposits	19,748	19,748	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,137,164	1,137,164	3
4	Supply Inventory (priced at)	8,860	8,860	4
5	Short-Term Investments			5
6	Prepaid Insurance	39,110	39,110	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	13,138	13,138	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,319,945	$ 1,439,874	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			14
15	Leasehold Improvements, at Historical Cost		983,365	15
16	Equipment, at Historical Cost	44,323	118,958	16
17	Accumulated Depreciation (book methods)	(25,756)	(622,024)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,567	$ 572,299	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,338,512	$ 2,012,173	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 267,884	$ 267,884	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,748	19,748	28
29	Short-Term Notes Payable	1,420,997	1,420,997	29
30	Accrued Salaries Payable	113,537	113,537	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,785	15,785	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,713	44,713	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	167,606	167,606	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,050,270	$ 2,050,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,195,100	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)**	$	$ 3,195,100	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,050,270	$ 5,245,370	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (711,758)	$ (3,233,197)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,338,512	$ 2,012,173	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (280,460)	1	
2	Restatements (describe):		2	
3	**Rounding**	(2)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (280,462)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(431,296)	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)**	$ (431,296)	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)**	$ (711,758)	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 4,365,617	1
2	Discounts and Allowances for all Levels	(577,114)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,788,503	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,282,059	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,282,059	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	348	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	232,417	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,159	19
20	Radiology and X-Ray		20
21	Other Medical Services	54,602	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 312,526	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,938	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,938	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	195	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 195	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,412,221	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	954,610	31
32	Health Care	2,016,016	32
33	General Administration	1,532,484	33
	B. Capital Expense		
34	Ownership	372,873	34
	C. Ancillary Expense		
35	Special Cost Centers	766,475	35
36	Provider Participation Fee	201,059	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,843,517	40
41	**Income before Income Taxes (line 30 minus line 40)****	(431,296)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (431,296)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,476,419	44
45	Private Pay - Net Inpatient Revenue	784,900	45
46	Medicare - Net Inpatient Revenue	527,184	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,788,503	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	3,600	3,827	$ 114,358	$ 29.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,351	14,023	370,916	26.45	3
4	Licensed Practical Nurses	19,866	20,971	535,075	25.51	4
5	CNAs & Orderlies	57,336	59,759	669,945	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,883	6,367	68,719	10.79	9
10	Activity Assistants					10
11	Social Service Workers	4,448	4,764	84,513	17.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,412	3,670	70,816	19.30	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,376	1,376	60,202	43.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,181	7,181	117,560	16.37	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	1,046	1,162	13,119	11.29	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	924	1,000	10,526	10.53	33
34	TOTAL (lines 1 - 33)	118,423	124,100	$ 2,115,749 *	$ 17.05	34

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	$ 489,340	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,131	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,030	11-03	44
45	Social Service Consultant	Monthly	3,286	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 514,787		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ryan Zank	Administrator	0.00%	$ 60,202
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,202

B. Administrative - Other

Description	Amount
Tutera Health Care Services	$ 340,997
TOTAL (agree to Schedule V, line 17, col. 3)	$ 340,997
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Non-Allowable Legal	Legal	$ 305
Polsinelli Shughart	Legal	2,999
TFG Consulting	Accounting	5,300
Self Maples & Copeland	Accounting	2,525
E-Health Data Solutions	Data Processing	5,790
Wescom Solutions	Data Processing	14,223
Forte LLC	Data Processing	140
Pinnacle Quality Insight	Customer Satisfaction	1,652
Zirmed	Revenue Cycle Mgmt	30
Thomas & Thorngren	Tax Credit	540
Property Valuation Services	R/E Assessment	100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 33,604

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,241
Unemployment Compensation Insurance	168,321
FICA Taxes	161,855
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	1,277
TOTAL (agree to Schedule V, line 22, col.8)	$ 441,694

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	67,129
Health Care Worker Background Check	10,103
(Indicate # of checks performed 53)	
Patient Background Checks	
Dues and Subscriptions	3,608
Licenses	667
Allocated from Tutera HC Services	639
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 84,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	575
Allocated from Tutera HC Services	3,308
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,883

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Dixon Healthcare & Rehab Ctr # 0051870 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 $6,266**

(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. $ **19,029** 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. $ **201,059**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **348**

(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?
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 out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.