

		FOR BHF USE					

LL1

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

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.

I. IDPH License ID Number: <u>0051292</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Hamilton Memorial Reha & HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2016</u> to <u>12/31/2016</u> 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.	
Address: <u>609 S Marshall Ave</u> <u>McLeansboro</u> <u>62859</u>			
Number City Zip Code			
County: <u>Hamilton</u>			
Telephone Number: <u>(618) 643-2325</u> Fax # <u>(618) 643-3528</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>5/17/2011</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Kevin Wellen</u>			
Telephone Number: <u>314-925-4446</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u>	
		(Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u>	
		(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Hamilton Memorial Reha & HCC

0051292 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,960</u>	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	<u>60</u>	TOTALS	<u>60</u>	<u>21,960</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,767</u>	<u>6,393</u>	<u>2,152</u>	<u>18,312</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,767</u>	<u>6,393</u>	<u>2,152</u>	<u>18,312</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.39%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐

NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐

NO ☒

I. On what date did you start providing long term care at this location?

Date started

5/17/2011

J. Was the facility purchased or leased after January 1, 1978?

YES ☒

Date

5/17/2011

NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒

NO ☐

If YES, enter number

of beds certified

60

and days of care provided

1,795

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒

NO ☐

Tax Year:

12/31/2016

Fiscal Year:

12/31/2016

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

Facility Name & ID Number Hamilton Memorial Reha & HCC # 0051292 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	174,726	19,381	525	194,632		194,632		194,632			1
2	Food Purchase		51,769		51,769		51,769	(2,187)	49,582			2
3	Housekeeping		16,138	71,555	87,693		87,693		87,693			3
4	Laundry		6,454	47,703	54,157		54,157		54,157			4
5	Heat and Other Utilities			105,767	105,767		105,767		105,767			5
6	Maintenance	22,669	5,010	51,011	78,690		78,690		78,690			6
7	Other (specify):*											7
8	TOTAL General Services	197,395	98,752	276,561	572,708		572,708	(2,187)	570,521			8
	B. Health Care and Programs											
9	Medical Director					6,000	6,000		6,000			9
10	Nursing and Medical Records	981,152	36,059	12,439	1,029,650	(6,000)	1,023,650		1,023,650			10
10a	Therapy											10a
11	Activities	33,778	1,613	4,541	39,932		39,932		39,932			11
12	Social Services	29,895		2,951	32,846		32,846		32,846			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,044,825	37,672	19,931	1,102,428		1,102,428		1,102,428			16
	C. General Administration											
17	Administrative	68,493			68,493		68,493		68,493			17
18	Directors Fees											18
19	Professional Services			59,678	59,678		59,678	135,747	195,425			19
20	Dues, Fees, Subscriptions & Promotions			9,321	9,321		9,321	(1,828)	7,493			20
21	Clerical & General Office Expenses	49,689	17,873	80,482	148,044		148,044	(57,518)	90,526			21
22	Employee Benefits & Payroll Taxes			232,114	232,114		232,114		232,114			22
23	Inservice Training & Education					279	279		279			23
24	Travel and Seminar			2,168	2,168	(279)	1,889	(745)	1,144			24
25	Other Admin. Staff Transportation			8,401	8,401		8,401	(5,246)	3,155			25
26	Insurance-Prop.Liab.Malpractice			92,110	92,110		92,110		92,110			26
27	Other (specify):*											27
28	TOTAL General Administration	118,182	17,873	484,274	620,329		620,329	70,410	690,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,360,402	154,297	780,766	2,295,465		2,295,465	68,223	2,363,688			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			19,272	19,272		19,272	24,290	43,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,780	7,780		7,780	(126)	7,654			32
33	Real Estate Taxes			2,204	2,204		2,204		2,204			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			4,525	4,525		4,525		4,525			35
36	Other (specify):*											36
37	TOTAL Ownership			213,781	213,781		213,781	(155,836)	57,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,510	272,327	336,837		336,837		336,837			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,102	133,102		133,102		133,102			42
43	Other (specify):* Marketing	32,387		19,143	51,530		51,530	(51,530)				43
44	TOTAL Special Cost Centers	32,387	64,510	424,572	521,469		521,469	(51,530)	469,939			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,392,789	218,807	1,419,119	3,030,715		3,030,715	(139,143)	2,891,572			45

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

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	(1,715)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,543)	21		18
19	Entertainment	(12,417)	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	(36,801)	21		24
25	Fund Raising, Advertising and Promotional	(19,143)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,597)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(41,088)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,430)		\$	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)	(19,713)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,713)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (139,143)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (160)	21	1
2	Vending Machine Revenues	(472)	2	2
3	Marketing Mileage	(5,246)	25	3
4	Annual Report	(250)	19	4
5	Marketing Seminar	(745)	24	5
6	PAC and lobbying portion of dues to IHCA	(1,828)	20	6
7	Marketing Salary	(32,387)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(41,088)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hamilton Memorial Reha & HCC # 0051292 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,187)	0	0	0	0	0	0	0	0	0	0	(2,187)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,187)	0	0	0	0	0	0	0	0	0	0	(2,187)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(250)	3,080	132,917	0	0	0	0	0	0	0	0	135,747	19
20	Fees, Subscriptions & Promotions	(1,828)	0	0	0	0	0	0	0	0	0	0	(1,828)	20
21	Clerical & General Office Expenses	(57,518)	0	0	0	0	0	0	0	0	0	0	(57,518)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(745)	0	0	0	0	0	0	0	0	0	0	(745)	24
25	Other Admin. Staff Transportation	(5,246)	0	0	0	0	0	0	0	0	0	0	(5,246)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(65,587)	3,080	132,917	0	0	0	0	0	0	0	0	70,410	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(67,774)	3,080	132,917	0	0	0	0	0	0	0	0	68,223	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Memorial Reha & HCC # 0051292 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	18,852	5,438	0	0	0	0	0	0	0	0	24,290	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(126)	0	0	0	0	0	0	0	0	0	0	(126)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(126)	(161,148)	5,438	0	0	0	0	0	0	0	0	(155,836)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(51,530)	0	0	0	0	0	0	0	0	0	0	(51,530)	43
44	TOTAL Special Cost Centers	(51,530)	0	0	0	0	0	0	0	0	0	0	(51,530)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(119,430)	(158,068)	138,355	0	0	0	0	0	0	0	0	(139,143)	45

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 Board Listing at PG6-Supp		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.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 180,000	TI- McLeansboro LLC	100.00%	\$	\$ (180,000)	1
2	V	19	Legal		TI- McLeansboro LLC	100.00%	450	450	2
3	V	19	Accounting		TI- McLeansboro LLC	100.00%	2,630	2,630	3
4	V	30	Depreciation		TI- McLeansboro LLC	100.00%	18,852	18,852	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			\$ 180,000			\$ 21,932	\$ * (158,068)	14

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

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	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Management Fee - Operating	\$ 28,374	Tutera Health Care Services	100.00%	\$ 161,291	\$ 132,917	15
16	V	30 Management Fee - Depreciation		Tutera Health Care Services	100.00%	5,438	5,438	16
17	V	21 Postage & Small Equip	1,308	Walnut Creek Management Company LLC		1,308		17
18	V	20 Subscription/Dues	75	Walnut Creek Management Company LLC		75		18
19	V	24 Seminar Expenses	565	Walnut Creek Management Company LLC		565		19
20	V	6 Plant Purchased Services	862	Metropolis Nursing & Rehab Center		862		20
21	V	10 Nursing Purchased Services	1,579	Coulterville Rehab & Health Care Center		1,579		21
22	V	24 Seminar Expenses	431	Coulterville Rehab & Health Care Center		431		22
23	V	26 Insurance	84,543	LTC Plus Insurance Inc		84,543		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		\$ 117,737			\$ 256,092	\$ * 138,355	39

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

Facility Name & ID Number

Hamilton Memorial Reha & HCC

0051292

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Tintera	100%	Auburn Rehabilitation & Health Care Center	Auburn, IL	TI - Metropolis	Metropolis, IL	Building Company	1
2			Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Manage	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Se	Kansas City, MO	Management Co	3
4			Carlville Rehabilitation & Health Care Center	Carlville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Crystal Pines Rehabilitation & Health Care Cen	Crystal Lake, IL	Walnut Creek New En	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 Li	Overland Park, KS	Independent/Assiste	7
8			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Carnegie Village Senio	Belton, MO	Independent/Assiste	8
9			Highland Rehabilitation & Health Care Center	Kansas City, MO	Continua Home Health	Kansas City, MO	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	Assisted Living	11
12			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Country Gardens Assi	Muskogee, OK	Assisted Living	12
13			Meridian Rehabilitation & Health Care Center	Wichita, KS	Gentilly Gardens Senio	Statesboro, GA	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care C	Independence, MO	Lamar Court Assisted	Overland Park, KS	Assisted Living	14
15			Montgomery Children's Specialty Center	Montgomery, AL	Oakley Courts Assisted	Freeport, IL	Assisted Living	15
16			Moweaqua Rehabilitation & Health Care Center	Moweaqua, IL	Rose Estates Assisted I	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons M	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, KS	Independent/Assiste	18
19			Charlton Place Rehabilitation & Health Care Ce	Deatsville, AL	Wesley Court Assisted	Boiling Springs, SC	Assisted Living	19
20			Startford Commons Rehabilitation & Health Ca	Overland Park, KS	Willow Place Assisted	Laurinburg, NC	Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Ca	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Cent	Hannibal, MO				22
23			Woodlawn Rehabilitation & Health Care Center	Wichita, KS				23
24			Holly Hill House	Sulphur, LA				24
25			Rosewood Nurisng Center	Lake Charles, LA				25
26			Beautiful Savior	Belton, MO				26
27			Coulterville Rehabilitation & Health Care Cente	Coulterville, IL				27
28			Greenfield Manor	Greenfield, IA				28
29			Griswold Care Center	Griswold, IA				29
30			Close to Home	Matthews, MO				30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Hamilton Memorial Reha & HCC # 0051292 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Hamilton Memorial Reha & HCC # 0051292 Report Period Beginning: 1/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Management Fee - Operating	Direct Costs	186,997,591	47	\$ 10,144,719	\$ 7,332,933	2,973,088	\$ 161,292	1
2	30	Management Fee - Depreciation	Direct Costs	186,997,591	47	342,075		2,973,088	5,439	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,486,794	\$ 7,332,933		\$ 166,731	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Tutera Investments		X	Note Payable			\$	1,233,263			\$ 7,780	1
2	Interest Income										(126)	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	1,233,263			\$ 7,654	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$	1,233,263			\$ 7,654	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	23,562	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.)				\$	12,883	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(10,679)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	12,883	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	2,204	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	14,399	8		
		2012	14,391	9		
		2013	15,721	10		
		2014	15,769	11		
		2015	12,883	12		
				FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2015	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Hamilton Memorial Reha & HCC COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 0051292

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	14,923	B. General Construction Type:	Exterior	Brick	Frame	Wood/Steel	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	-------------------	--------------------------	----------

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (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? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (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 ☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	14,923	2011	\$ 28,500	1
2					2
3	TOTALS	14,923		\$ 28,500	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60		2011	1970	\$ 399,000	\$ 14,509	39	\$ 14,509		\$ 81,616
5										
6										
7										
8										
	Improvement Type**									
9	Therapy Room			2011	96,066	9,607	10	9,607		48,033
10	Laundry Room			2011	22,902	2,290	10	2,290		11,451
11	Breezeway Renovation			2012	10,460	844	15	844		2,864
12	Flooring			2014	17,174	1,469	15	1,469		3,959
13	Sprinkler System Pipe Insulation			2014	7,395	494	20	494		1,305
14	HVAC Repairs			2016	6,256	208	10	208		208
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34	Home Office and Allocated Depreciation					5,438		5,438		
35										
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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 559,253	\$ 34,859		\$ 34,859	\$	\$ 149,436	70

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

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	\$78,807	\$7,529	\$7,529	\$	10	\$67,038	71
72	Current Year Purchases	12,812	1,174	1,174		10	1,174	72
73	Fully Depreciated Assets	39,599				10	39,599	73
74								74
75	TOTALS	\$131,218	\$8,703	\$8,703	\$		\$107,811	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		Van	8/1/2011	\$10,636	\$	\$	\$	5	\$10,636
77									
78									
79									
80	TOTALS			\$10,636	\$	\$	\$		\$10,636

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	729,607
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	43,562
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	43,562
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	267,883

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		\$	\$	
87				
88				
89				
90				
91	TOTALS	\$	\$	

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

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: *

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: \$ 4,525
- Description: Copier

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* 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.

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

☒ 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)	\$			

(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.

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	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V39-3	hrs	\$	6,360	\$ 103,033	\$	6,360	\$ 103,033	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		2,554	41,368		2,554	41,368	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		7,105	115,098	469	7,105	115,567	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				48,950		48,950	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					12,828	15,091		27,919	13
14	TOTAL			\$	16,019	\$ 272,327	\$ 64,510	16,019	\$ 336,837	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.

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	\$ 37,980	\$ 178,807	1
2	Cash-Patient Deposits	6,901	6,901	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	538,871	538,871	3
4	Supply Inventory (priced at)	13,168	13,168	4
5	Short-Term Investments			5
6	Prepaid Insurance	90,297	90,297	6
7	Other Prepaid Expenses	27,654	32,440	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	6,514	6,514	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 721,385	\$ 866,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		28,500	13
14	Buildings, at Historical Cost		399,000	14
15	Leasehold Improvements, at Historical Cost	160,253	160,253	15
16	Equipment, at Historical Cost	94,354	141,854	16
17	Accumulated Depreciation (book methods)	(144,919)	(267,883)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other Long-Term Assets	22,512	22,512	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 132,200	\$ 484,236	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 853,585	\$ 1,351,234	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,686	\$ 121,686	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,901	6,901	28
29	Short-Term Notes Payable	1,233,263	1,233,263	29
30	Accrued Salaries Payable	98,528	98,528	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,537	38,537	31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,883	12,883	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,511,798	\$ 1,511,798	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	27,909	27,909	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,909	\$ 27,909	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,539,707	\$ 1,539,707	46
47	TOTAL EQUITY(page 18, line 24)	\$ (686,122)	\$ (188,473)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 853,585	\$ 1,351,234	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (738,548)	1
2	Restatements (describe):		2
3	Prior year adjustments	(19,528)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (758,076)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,954	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)	\$ 71,954	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)	\$ (686,122)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hamilton Memorial Reha & HCC

0051292

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,257,415	1
2	Discounts and Allowances for all Levels	(500,997)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,756,418	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,215,344	6
7	Oxygen	108	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,215,452	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	472	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,715	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	97,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,997	19
20	Radiology and X-Ray		20
21	Other Medical Services	14,915	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 130,734	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	126	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 126	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(61)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (61)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,102,669	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	572,708	31
32	Health Care	1,102,428	32
33	General Administration	620,329	33
	B. Capital Expense		
34	Ownership	213,781	34
	C. Ancillary Expense		
35	Special Cost Centers	388,367	35
36	Provider Participation Fee	133,102	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,030,715	40
41	Income before Income Taxes (line 30 minus line 40)**	71,954	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 71,954	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,266,364	44
45	Private Pay - Net Inpatient Revenue	809,482	45
46	Medicare - Net Inpatient Revenue	(249,030)	46
47	Other-(specify) <u>Insurance</u>	(70,398)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,756,418	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,389	3,725	\$ 93,926	\$ 25.22	1
2	Assistant Director of Nursing	0	0			2
3	Registered Nurses	9,357	9,898	253,310	25.59	3
4	Licensed Practical Nurses	8,411	9,310	180,433	19.38	4
5	CNAs & Orderlies	36,406	38,924	453,483	11.65	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	0	0			9
10	Activity Assistants	2,906	3,174	33,778	10.64	10
11	Social Service Workers	1,792	2,000	29,895	14.95	11
12	Dietician	0	0			12
13	Food Service Supervisor	0	0			13
14	Head Cook	0	0			14
15	Cook Helpers/Assistants	14,483	15,559	174,726	11.23	15
16	Dishwashers	0	0			16
17	Maintenance Workers	1,494	1,663	22,669	13.63	17
18	Housekeepers	0	0			18
19	Laundry	0	0			19
20	Administrator	1,824	2,000	68,493	34.25	20
21	Assistant Administrator	0	0			21
22	Other Administrative	0	0			22
23	Office Manager	0	0			23
24	Clerical	3,123	3,370	49,689	14.74	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	0	0			28
29	Resident Services Coordinator	0	0			29
30	Habilitation Aides (DD Homes)	0	0			30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0			32
33	Other(specify) See Supplemental	1,820	2,000	32,387	16.19	33
34	TOTAL (lines 1 - 33)	85,005	91,623	\$ 1,392,789 *	\$ 15.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 525	V01-3	35
36	Medical Director	Monthly	6,000	V18-3	36
37	Medical Records Consultant	Monthly	982	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,875	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,541	V11-3	44
45	Social Service Consultant	Monthly	2,951	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,874		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		2,256	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 2,256		53

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>IL Healthcare Association \$4,224</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>No</u> <u>N/A</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 yrs</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>9,157</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>133,102</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? (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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>No</u> Indicate the amount. \$ <u>0</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> <u>N/A</u> <u>N/A</u> <u>100%</u> <u>No</u> <u>N/A</u> <u>No</u> <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees	<u>Yes</u>