

		FOR BHF USE					

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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>0050971</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lakeland Rehab & 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>800 W Temple Avenue</u> <u>Effingham</u> <u>62401</u>																									
Number City Zip Code																									
County: <u>Effingham</u>																									
Telephone Number: <u>217-342-2171</u> Fax # <u>217-342-2258</u>																									
HFS ID Number: _____		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td>(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(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>													
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	(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>																								
Date of Initial License for Current Owners: <u>7/01/10</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Kevin Wellen</u> Telephone Number: <u>314-925-4446</u>																									
Email Address: _____																									

Facility Name & ID Number Lakeland Rehab & HCC

0050971 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 <u>N/A</u>					
	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>156</u>	Skilled (SNF)	<u>156</u>	<u>57,096</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>156</u>	TOTALS	<u>156</u>	<u>57,096</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>17,932</u>	<u>10,751</u>	<u>12,794</u>	<u>41,477</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>17,932</u>	<u>10,751</u>	<u>12,794</u>	<u>41,477</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.64%

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 7/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/01/10 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 156 and days of care provided 9,870

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 Lakeland Rehab & HCC # 0050971 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		5,498	595,533	601,031		601,031		601,031			1
2	Food Purchase		27,319		27,319		27,319	(2,217)	25,102			2
3	Housekeeping		13,436	181,078	194,514		194,514		194,514			3
4	Laundry		17,661	120,719	138,380		138,380		138,380			4
5	Heat and Other Utilities			144,000	144,000		144,000		144,000			5
6	Maintenance	69,961	14,519	93,498	177,978		177,978	13,469	191,447			6
7	Other (specify):*											7
8	TOTAL General Services	69,961	78,433	1,134,828	1,283,222		1,283,222	11,252	1,294,474			8
	B. Health Care and Programs											
9	Medical Director					8,400	8,400		8,400			9
10	Nursing and Medical Records	2,656,900	89,132	14,380	2,760,412	(8,400)	2,752,012		2,752,012			10
10a	Therapy											10a
11	Activities	142,606	12,518	3,583	158,707		158,707		158,707			11
12	Social Services	57,576		3,583	61,159		61,159		61,159			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,857,082	101,650	21,546	2,980,278		2,980,278		2,980,278			16
	C. General Administration											
17	Administrative	123,386			123,386		123,386		123,386			17
18	Directors Fees											18
19	Professional Services			163,484	163,484		163,484	394,023	557,507			19
20	Dues, Fees, Subscriptions & Promotions			27,186	27,186		27,186	(4,541)	22,645			20
21	Clerical & General Office Expenses	149,799	38,500	1,069,993	1,258,292		1,258,292	(1,066,264)	192,028			21
22	Employee Benefits & Payroll Taxes			421,262	421,262		421,262		421,262			22
23	Inservice Training & Education					540	540		540			23
24	Travel and Seminar			5,239	5,239	(540)	4,699		4,699			24
25	Other Admin. Staff Transportation			2,802	2,802		2,802		2,802			25
26	Insurance-Prop.Liab.Malpractice			228,625	228,625		228,625	9,813	238,438			26
27	Other (specify):*											27
28	TOTAL General Administration	273,185	38,500	1,918,591	2,230,276		2,230,276	(666,969)	1,563,307			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,200,228	218,583	3,074,965	6,493,776		6,493,776	(655,717)	5,838,059			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			34,055	34,055		34,055	290,254	324,309			30
31	Amortization of Pre-Op. & Org.							110,500	110,500			31
32	Interest			367	367		367	482,417	482,784			32
33	Real Estate Taxes			86,400	86,400		86,400	11,721	98,121			33
34	Rent-Facility & Grounds			395,280	395,280		395,280	(395,280)				34
35	Rent-Equipment & Vehicles			17,459	17,459		17,459		17,459			35
36	Other (specify):* Mortgage Ins							17,869	17,869			36
37	TOTAL Ownership			533,561	533,561		533,561	517,481	1,051,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		422,342	1,596,119	2,018,461		2,018,461		2,018,461			39
40	Barber and Beauty Shops			2,986	2,986		2,986		2,986			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			277,517	277,517		277,517		277,517			42
43	Other (specify):* Marketing	37,568		43,674	81,242		81,242	(81,242)				43
44	TOTAL Special Cost Centers	37,568	422,342	1,920,296	2,380,206		2,380,206	(81,242)	2,298,964			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,237,796	640,925	5,528,822	9,407,543		9,407,543	(219,478)	9,188,065			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		22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,995)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(18,147)	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	(9,178)	21		24
25	Fund Raising, Advertising and Promotional	(43,674)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(27,044)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(89,201)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (189,239)		\$	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)	(30,239)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (30,239)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (219,478)		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	\$ (44,875)	21	1
2	Vending Machine Revenue	(2,217)	02	2
3	Marketing Salary	(37,568)	43	3
4				4
5	PAC Dues	(3,676)	20	5
6	Annual Report	(20)	20	6
7	Chamber of Commerce Dues	(845)	20	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
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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	(89,201)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeland Rehab & HCC# 0050971

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	(2,217)	0	0	0	0	0	0	0	0	0	0	(2,217)	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	13,469	0	0	0	0	0	0	0	0	0	13,469	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,217)	13,469	0	0	0	0	0	0	0	0	0	11,252	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,225	383,798	0	0	0	0	0	0	0	0	394,023	19
20	Fees, Subscriptions & Promotions	(4,541)	0	0	0	0	0	0	0	0	0	0	(4,541)	20
21	Clerical & General Office Expenses	(99,244)	0	(967,020)	0	0	0	0	0	0	0	0	(1,066,264)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,813	0	0	0	0	0	0	0	0	0	9,813	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(103,785)	20,038	(583,222)	0	0	0	0	0	0	0	0	(666,969)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,002)	33,507	(583,222)	0	0	0	0	0	0	0	0	(655,717)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeland Rehab & HCC # 0050971 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	274,713	15,541	0	0	0	0	0	0	0	0	290,254	30
31	Amortization of Pre-Op. & Org.	0	110,500	0	0	0	0	0	0	0	0	0	110,500	31
32	Interest	(1,995)	484,412	0	0	0	0	0	0	0	0	0	482,417	32
33	Real Estate Taxes	0	11,721	0	0	0	0	0	0	0	0	0	11,721	33
34	Rent-Facility & Grounds	0	(395,280)	0	0	0	0	0	0	0	0	0	(395,280)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	17,869	0	0	0	0	0	0	0	0	0	17,869	36
37	TOTAL Ownership	(1,995)	503,935	15,541	0	0	0	0	0	0	0	0	517,481	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):*	(81,242)	0	0	0	0	0	0	0	0	0	0	(81,242)	43
44	TOTAL Special Cost Centers	(81,242)	0	0	0	0	0	0	0	0	0	0	(81,242)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(189,239)	537,442	(567,681)	0	0	0	0	0	0	0	0	(219,478)	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	\$ 395,280	TI-Effingham, LLC	100.00%	\$	(395,280)	1
2	V	32	Interest		TI-Effingham, LLC	100.00%	484,412	484,412	2
3	V	19	Legal		TI-Effingham, LLC	100.00%	450	450	3
4	V	19	Accounting		TI-Effingham, LLC	100.00%	9,775	9,775	4
5	V	36	Mortgage Insurance Premium		TI-Effingham, LLC	100.00%	17,869	17,869	5
6	V	30	Depreciation		TI-Effingham, LLC	100.00%	274,713	274,713	6
7	V	31	Amortization		TI-Effingham, LLC	100.00%	110,500	110,500	7
8	V	06	Maintenance		TI-Effingham, LLC	100.00%	13,469	13,469	8
9	V	33	Real Estate Taxes	86,400	TI-Effingham, LLC	100.00%	98,121	11,721	9
10	V	26	Insurance	6,750	TI-Effingham, LLC	100.00%	16,563	9,813	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 488,430			\$ 1,025,872	\$ * 537,442	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 - Operating	\$ 77,020	Tutera Health Care Services	100.00%	\$ 460,818	\$ 383,798	15
16	V	30 Management - Depreciation		Tutera Health Care Services	100.00%	15,541	15,541	16
17	V	21 Management Fees	514,020	Tutera Health Care Services	100.00%		(514,020)	17
18	V	21 Postage & Small Equipment	8,514	Walnut Creek Management Company LLC		8,514		18
19	V	24 Seminar Expenses	1,040	Walnut Creek Management Company LLC		1,040		19
20	V	21 Assest Management Fee	453,000	JCT Capital LLC			(453,000)	20
21	V	26 Insurance	219,813	LTC Plus Insurance Inc		219,813		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		\$ 1,273,407			\$ 705,726	\$ * (567,681)	39

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

Facility Name & ID Number

Lakeland Rehab & HCC

0050971

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			Hamilton Memorial Rehabilitation & Health Ca	McLeansboro, 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			Metropolis Rehabilitation & Health Care Center	Metropolis, 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 Car	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Cent	Hannibal, MO				22
23			Woodlawn Rehabilitation & Health Care Center	Wichita, KS				23
24			Holly Hill House	Sulphur, LA				24
25			Rosewood 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 Lakeland Rehab & HCC # 0050971 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

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	HUD		X	Mortgage			\$	8,600,000			\$	484,412	1
2	Tutera Investments		X	Note Payable				899,024				367	2
3	Interest Income											(1,995)	3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	9,499,024			\$	482,784	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	9,499,024			\$	482,784	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 17,869 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	88,338	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.)			\$	93,229	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,891	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	93,230	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.			\$	98,121	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	83,931	8	
		2012	84,782	9	
		2013	86,645	10	
		2014	88,338	11	
		2015	93,229	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakeland Rehab & HCC COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0050971

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 03-11-020-019	Long Term Care Facility	\$ 93,229.38	\$ 93,229.38
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 93,229.38	\$ 93,229.38

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	50,500	B. General Construction Type:	Exterior	Brick	Frame	Block	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	Land		2010	\$ 612,285	1
2					2
3	TOTALS			\$ 612,285	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	156		2010	1971	\$ 5,081,962	\$ 184,799	27	\$ 184,799	\$	\$ 1,201,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10		Physical Therapy Room Renovations		2012	102,049	5,102	20	5,102		26,363	10
11		Water Heater		2012	17,065	853	10	853		12,159	11
12		Design & Construction		2013	195,075	16,518	15	16,518		46,414	12
13		Attic Ventilation & Duct Replacement		2016	9,945	746	10	746		746	13
14		Land Improvements (TI - Effingham)		2011	14,917	2,486	5	2,486		14,917	14
15		Building Renovations (TI Effingham)		2012	157,942	5,743	27	5,743		24,888	15
16											16
17		HO Depreciation Allocation				15,541		15,541			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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,578,955	\$ 231,788		\$ 231,788	\$	\$ 1,326,678	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	\$616,626	\$80,763	\$80,763	\$	VARIOUS	\$512,598	71
72	Current Year Purchases	11,556	241	241		12	241	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$628,182	\$81,004	\$81,004	\$		\$512,839	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	6/1/2012	\$57,587	\$11,517	\$11,517	\$	5	\$52,788
77									
78									
79									
80	TOTALS			\$57,587	\$11,517	\$11,517	\$		\$52,788

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)			\$	6,877,009
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	324,309
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	324,309
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)			\$	1,892,305

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?
16. Rental Amount for movable equipment: \$17,459Description: Dietary, Laundry, Plant, and Copier (See WTB)
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

C. Vehicle Rental (See instructions.)

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

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

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

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.
- (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.

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	

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	\$	13,845	\$ 514,197	\$	13,845	\$	514,197
2	Licensed Speech and Language Development Therapist	V39-3	hrs		5,056	208,619		5,056		208,619
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	V39-3	hrs		14,803	743,611	3,505	14,803		747,116
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	V39-2	# of prescrpts				331,326			331,326
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify):									
13	Other (specify): See Supplemental					129,692	87,511			217,203
14	TOTAL			\$	33,704	\$ 1,596,119	\$ 422,342	33,704	\$	2,018,461

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 307,669	\$ 404,934	1
2	Cash-Patient Deposits	11,533	11,533	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,690,810	1,710,332	3
4	Supply Inventory (priced at)	8,634	8,634	4
5	Short-Term Investments			5
6	Prepaid Insurance	226,145	234,710	6
7	Other Prepaid Expenses	144,408	144,408	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	37,342	37,342	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,426,541	\$ 2,551,893	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		612,285	13
14	Buildings, at Historical Cost		5,239,904	14
15	Leasehold Improvements, at Historical Cost	324,134	339,051	15
16	Equipment, at Historical Cost	114,262	685,769	16
17	Accumulated Depreciation (book methods)	(167,838)	(1,892,305)	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	47,249	109,982	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 317,807	\$ 5,094,686	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,744,348	\$ 7,646,579	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 513,749	\$ 513,749	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,533	11,533	28
29	Short-Term Notes Payable	899,024	899,024	29
30	Accrued Salaries Payable	216,871	216,871	30
31	Accrued Taxes Payable (excluding real estate taxes)	124,286	124,286	31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,229	32
33	Accrued Interest Payable		29,663	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)	\$ 1,765,463	\$ 1,888,355	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,600,000	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)	\$	\$ 8,600,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,765,463	\$ 10,488,355	46
47	TOTAL EQUITY(page 18, line 24)	\$ 978,885	\$ (2,841,776)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,744,348	\$ 7,646,579	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 968,655	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 968,655	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	917,604	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	(907,374)	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)	\$ 10,230	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)	\$ 978,885	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lakeland Rehab & HCC

0050971

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	\$ 7,152,840	1
2	Discounts and Allowances for all Levels	(5,413,146)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,739,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,559,861	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,559,861	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	681,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,296	19
20	Radiology and X-Ray		20
21	Other Medical Services	222,671	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 976,505	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,995	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,995	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	47,092	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 47,092	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,325,147	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,283,222	31
32	Health Care	2,980,278	32
33	General Administration	2,230,276	33
	B. Capital Expense		
34	Ownership	533,561	34
	C. Ancillary Expense		
35	Special Cost Centers	2,102,689	35
36	Provider Participation Fee	277,517	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,407,543	40
41	Income before Income Taxes (line 30 minus line 40)**	917,604	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 917,604	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,433,584	44
45	Private Pay - Net Inpatient Revenue	1,687,180	45
46	Medicare - Net Inpatient Revenue	(2,173,270)	46
47	Other-(specify) Insurance	(207,800)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,739,694	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	5,375	5,790	\$ 166,363	\$ 28.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,969	22,093	619,558	28.04	3
4	Licensed Practical Nurses	26,387	27,999	597,415	21.34	4
5	CNAs & Orderlies	90,194	94,230	1,231,708	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,301	10,886	142,606	13.10	10
11	Social Service Workers	4,188	4,444	57,576	12.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,923	4,235	69,961	16.52	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,896	2,000	123,386	61.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,845	10,461	149,799	14.32	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	1,291	1,459	17,719	12.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,641	3,846	61,705	16.04	33
34	TOTAL (lines 1 - 33)	178,010	187,443	\$ 3,237,796 *	\$ 17.27	34

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	\$ 595,533	V01-3	35
36	Medical Director	Monthly	8,400	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,985	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,583	V11-3	44
45	Social Service Consultant	Monthly	3,583	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 620,084		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ (4,590)	V10-3	50
51	Licensed Practical Nurses		331	V10-3	51
52	Certified Nurse Assistants/Aides		759	V10-3	52
53	TOTAL (lines 50 - 52)		\$ (3,500)		53

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Wade	Admin	0	\$ 123,386
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,386

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	\$ 40,612
Tutera Health Care Services	Data Processing	13,099
Various	Data Processing	94,187
Marcum, LLP	Accounting	8,731
Property Valuation Services	Compliance	100
Curaspan	Data Processing	2,675
Allscripts	General Prof Svcs	1,710
Pinnacle Quality Insight	Customer Satisfaction Survey	2,370
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 163,484

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 64,904
Unemployment Compensation Insurance	
FICA Taxes	265,930
Employee Health Insurance	67,270
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	19,197
TOTAL (agree to Schedule V, line 22, col.8)	\$ 417,301

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	4,557
Health Care Worker Background Check (Indicate # of checks performed 248)	2,480
IL Healthcare Association	9,306
Dues & Subscriptions	8,853
Less: Public Relations Expense	(4,541)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,645

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,699
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,699

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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 Healthcare Association \$9,306

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(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? 12 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,028 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. \$ 277,517
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0

(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? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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