

		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>0053595</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Moweaqua Rehab & HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</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>525 South Macon St</u> <u>Moweaqua</u> <u>62550</u>																									
Number City Zip Code																									
County: <u>Shelby</u>																									
Telephone Number: <u>217-768-3951</u> Fax # <u>217-768-4971</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">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>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</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>314-925-4300</u> Fax # <u>314-925-4350</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(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>314-925-4300</u> Fax # <u>314-925-4350</u>												
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	(Telephone) <u>314-925-4300</u> Fax # <u>314-925-4350</u>																								
Date of Initial License for Current Owners: <u>6/1/2015</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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	☐ 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, CPA</u> Telephone Number: <u>314-925-4446</u>																									
Email Address: _____																									

Facility Name & ID Number Moweaqua Rehab & HCC

0053595 Report Period Beginning: 01/01/2016 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>70</u>	Skilled (SNF)	<u>70</u>	<u>25,620</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>70</u>	TOTALS	<u>70</u>	<u>25,620</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>5,334</u>	<u>3,573</u>	<u>2,771</u>	<u>11,678</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>5,334</u>	<u>3,573</u>	<u>2,771</u>	<u>11,678</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.58%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☒ 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 06/01/2015

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/01/2015 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 70 and days of care provided 1,036

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Moweaqua Rehab & HCC # 0053595 Report Period Beginning: 01/01/2016 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	103,948	11,763	6,084	121,795		121,795		121,795			1
2	Food Purchase		75,821		75,821		75,821	(3,575)	72,246			2
3	Housekeeping	80,033	11,276	942	92,251		92,251		92,251			3
4	Laundry	24,369	18,657	4,650	47,676		47,676		47,676			4
5	Heat and Other Utilities			47,771	47,771		47,771		47,771			5
6	Maintenance	47,728	14,720	86,129	148,577		148,577	47,120	195,697			6
7	Other (specify):*											7
8	TOTAL General Services	256,078	132,237	145,576	533,891		533,891	43,545	577,436			8
	B. Health Care and Programs											
9	Medical Director					18,000	18,000		18,000			9
10	Nursing and Medical Records	585,038	52,807	209,595	847,440	(18,000)	829,440		829,440			10
10a	Therapy											10a
11	Activities	25,233	3,057	3,365	31,655		31,655		31,655			11
12	Social Services	39,944		3,381	43,325		43,325		43,325			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	650,215	55,864	216,341	922,420		922,420		922,420			16
	C. General Administration											
17	Administrative	76,057			76,057		76,057		76,057			17
18	Directors Fees											18
19	Professional Services			71,711	71,711		71,711	121,806	193,517			19
20	Dues, Fees, Subscriptions & Promotions			18,502	18,502		18,502	(1,825)	16,677			20
21	Clerical & General Office Expenses	51,035	17,041	287,385	355,461		355,461	(282,529)	72,932			21
22	Employee Benefits & Payroll Taxes			177,223	177,223		177,223		177,223			22
23	Inservice Training & Education					688	688		688			23
24	Travel and Seminar			5,513	5,513	(688)	4,825	(130)	4,695			24
25	Other Admin. Staff Transportation			12,698	12,698		12,698	(3,308)	9,390			25
26	Insurance-Prop.Liab.Malpractice			124,398	124,398		124,398		124,398			26
27	Other (specify):*											27
28	TOTAL General Administration	127,092	17,041	697,430	841,563		841,563	(165,986)	675,577			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,033,385	205,142	1,059,347	2,297,874		2,297,874	(122,441)	2,175,433			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			16,874	16,874		16,874	110,482	127,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,918	9,918		9,918	14,780	24,698			32
33	Real Estate Taxes			99,490	99,490		99,490		99,490			33
34	Rent-Facility & Grounds			72,000	72,000		72,000	(72,000)				34
35	Rent-Equipment & Vehicles			4,604	4,604		4,604		4,604			35
36	Other (specify):*											36
37	TOTAL Ownership			202,886	202,886		202,886	53,262	256,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,995	216,215	297,210		297,210		297,210			39
40	Barber and Beauty Shops		92		92		92		92			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,068	102,068		102,068		102,068			42
43	Other (specify):* Marketing & AL	117,076		60,888	177,964		177,964	(177,964)				43
44	TOTAL Special Cost Centers	117,076	81,087	379,171	577,334		577,334	(177,964)	399,370			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,150,461	286,229	1,641,404	3,078,094		3,078,094	(247,143)	2,830,951			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	(2,967)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27)	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	(38,430)	21		18
19	Entertainment	(5,124)	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	(91,027)	21		24
25	Fund Raising, Advertising and Promotional	(19,042)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(188,463)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (345,080)		\$	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)	97,937		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 97,937		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (247,143)		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	Miscellaneous Income	\$ (23,670)	21	1
2	Marketing Mileage	(3,308)	25	2
3	Marketing Seminars	(130)	24	3
4	Marketing Salary	(30,331)	43	4
5	Retirement Center Expenses	(128,591)	43	5
6				6
7	IL Healthcare Association PAC & Lobbying Dues	(1,825)	20	7
8	Vending Machine Income	(608)	2	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	(188,463)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Moweaqua Rehab & HCC# 0053595

Report Period Beginning:

01/01/2016

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	(3,575)	0	0	0	0	0	0	0	0	0	0	(3,575)	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	47,120	0	0	0	0	0	0	0	0	0	47,120	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,575)	47,120	0	0	0	0	0	0	0	0	0	43,545	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	450	121,356	0	0	0	0	0	0	0	0	121,806	19
20	Fees, Subscriptions & Promotions	(1,825)	0	0	0	0	0	0	0	0	0	0	(1,825)	20
21	Clerical & General Office Expenses	(158,251)	0	(124,278)	0	0	0	0	0	0	0	0	(282,529)	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	(130)	0	0	0	0	0	0	0	0	0	0	(130)	24
25	Other Admin. Staff Transportation	(3,308)	0	0	0	0	0	0	0	0	0	0	(3,308)	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	(163,514)	450	(2,922)	0	0	0	0	0	0	0	0	(165,986)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(167,089)	47,570	(2,922)	0	0	0	0	0	0	0	0	(122,441)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Moweaqua Rehab & HCC # 0053595 Report Period Beginning: 01/01/2016 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	105,041	5,441	0	0	0	0	0	0	0	0	110,482	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(27)	14,807	0	0	0	0	0	0	0	0	0	14,780	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(72,000)	0	0	0	0	0	0	0	0	0	(72,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27)	47,848	5,441	0	0	0	0	0	0	0	0	53,262	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):*	(177,964)	0	0	0	0	0	0	0	0	0	0	(177,964)	43
44	TOTAL Special Cost Centers	(177,964)	0	0	0	0	0	0	0	0	0	0	(177,964)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(345,080)	95,418	2,519	0	0	0	0	0	0	0	0	(247,143)	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 Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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	\$ 72,000	JCTFLP-Moweagua, LLC	100.00%	\$	(72,000)	1
2	V	32	Interest		JCTFLP-Moweagua, LLC	100.00%	14,807	14,807	2
3	V	19	Legal		JCTFLP-Moweagua, LLC	100.00%	450	450	3
4	V	6	Maintenance		JCTFLP-Moweagua, LLC	100.00%	47,120	47,120	4
5	V	30	Depreciation		JCTFLP-Moweagua, LLC	100.00%	105,041	105,041	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 72,000			\$ 167,418	\$ * 95,418	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: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Management - Operating	\$ 40,016	Tutera Health Care Services	100.00%	\$ 161,372	\$ 121,356	15
16	V	30 Management - Depreciation		Tutera Health Care Services	100.00%	5,441	5,441	16
17	V	21 Management Fee	124,278	Tutera Health Care Services	100.00%		(124,278)	17
18	V	6 Small Equipment Purchases	2,548	Walnut Creek Management Company, LLC		2,548		18
19	V	20 Want Ads	227	Walnut Creek Management Company, LLC		227		19
20	V	21 Small Equipment Purchases	5,510	Walnut Creek Management Company, LLC		5,510		20
21	V	24 Seminar Expenses	538	Walnut Creek Management Company, LLC		538		21
22	V	21 Postage	481	Walnut Creek Management Company, LLC		481		22
23	V	10 Nursing Supplies	191	Walnut Creek Management Company, LLC		191		23
24	V	40 Beauty Supplies	17	Walnut Creek Management Company, LLC		17		24
25	V	10 Nursing Services	7,091	Carlinville Rehab & Health Care Center		7,091		25
26	V	6 Plant Services	1,927	Carlinville Rehab & Health Care Center		1,927		26
27	V	10 Nursing Services	27	Hillsboro Rehab & Health Care Center		27		27
28	V	6 Plant Services	158	Hillsboro Rehab & Health Care Center		158		28
29	V	21 A&G Services	300	Hillsboro Rehab & Health Care Center		300		29
30	V	25 Mileage Reimbursement	380	Hillsboro Rehab & Health Care Center		380		30
31	V	10 Nursing Services	614	Auburn Nursing & Rehab		614		31
32	V	6 Plant Services	560	Auburn Nursing & Rehab		560		32
33	V	25 Mileage Reimbursement	820	Auburn Nursing & Rehab		820		33
34	V	24 Seminar Expenses	75	Auburn Nursing & Rehab		75		34
35	V	10 Nursing Services	1,455	Lakeland Rehab & Health Care Center		1,455		35
36	V	6 Plant Services	2,006	Lakeland Rehab & Health Care Center		2,006		36
37	V	10 Nursing Services	1,134	Coulterville Rehab & Health Care Center		1,134		37
38	V	26 Insurance	107,652	LTC Plus Insurance, Inc		107,652		38
39	Total		\$ 298,005			\$ 300,524	\$ * 2,519	39

* 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.

☒ X

 YES

☐ NO

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

1		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)	
15	V	10	Nursing Services	\$ 224	Mattoon Rehab & Health Care Center		\$ 224	\$	15
16	V	6	Plant Services	700	Mattoon Rehab & Health Care Center		700		16
17	V	25	Mileage Reimbursement	352	Mattoon Rehab & Health Care Center		352		17
18	V	10	Nursing Services	452	Metropolis Nursing & Rehab Center		452		18
19	V	21	A&G Services	1,092	Metropolis Nursing & Rehab Center		1,092		19
20	V	10	Nursing Services	6,268	Hamilton Memorial Nursing & Rehab		6,268		20
21	V	25	Mileage Reimbursement	773	Hamilton Memorial Nursing & Rehab		773		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			\$ 9,861			\$ 9,861	\$ *	39

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

Facility Name & ID Number

Moweaqua Rehab & HCC

0053595

Report Period Beginning:

01/01/2016

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	JCT Family Limited Partnership	99%	Auburn Rehabilitation & health Care Center	Auburn, IL	JCT FLP - Moweaqua	Moweaqua, IL	Building Comp	1
2	JCT Investments, LLC	1%	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 Comp	6
7			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	7
8			Hamilton Memorial Rehabilitation & Health Ca	McLeansboro, IL	Carneie Village	Belton, MO	IL/AL	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 City, MO	Hospice	10
11			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice MO	Kansas City, MO	Hospice	11
12			Mattoon Rehabilitation & Health Care Center	Mattoon, IL	Country Gardens	Muskogee, OK	AL	12
13			Meridian Rehabilitation & Health Care Center	Wichita, KS	Gentilly Gardens	Statesboro, GA	AL	13
14			Metropolis Rehabilitation & Health Care Center	Metropolis, IL	Lamar Court AL	Overland Park, KS	AL	14
15			Monterey Park Rehabilitation & Health Care C	Independence, MO	Oakley Courts AL	Freeport, OL	AL	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Rose Estates AL	Overland Park, KS	AL	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior	Kansas City, KS	IL/AL	18
19			Charlton Place Rehabilitation & Health Care C	Deatsville, AL	Wesley Court AL	Boiling Springs, SC	AL	19
20			Stratford Commons Rehabilitation & Health Ca	Overland Park, KS	Willow Place AL	Laurinburg, NC	AL	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 Nursing Center	Lake Charles, LA				25
26			Beautiful Savior	Belton, MO				26
27			Coulterville Rehabilitation & Health Care Cent	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 Moweaqua Rehab & HCC # 0053595 Report Period Beginning: 01/01/2016 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 Moweaqua Rehab & HCC # 0053595 Report Period Beginning: 01/01/2016 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, MO 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	2,974,498	\$ 161,368	1
2	30	Management Fee - Depreciation	Direct Costs	186,997,591	47	342,075		2,974,498	5,441	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		\$ 166,809	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			\$	2,141,666			\$ 9,918	1	
2	Tutera Inv (JCTFLP)	X		Note Payable				1,969,043				2	
3	Moqweaqua NH Ventures		X	Note Payable				433,333			14,807	3	
4	Interest Income										(27)	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	4,544,042			\$ 24,698	9	
	B. Non-Facility Related*												
10	Allocated from Columbia 7611 LLC		X									10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$	14	
15	TOTALS (line 9+line14)						\$	4,544,042			\$ 24,698	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.	\$	90,311	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.)			\$	94,901	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,590	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	94,900	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.			\$	99,490	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	91,782	8		
	2012	92,285	9		
	2013	90,111	10		
	2014	90,646	11		
	2015	94,901	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 Moweaqua Rehab & HCC COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0053595

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. <u>1001-31-00-200-011</u>	<u>Facility</u>	\$ <u>94,900.78</u>	\$ <u>94,900.78</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>94,900.78</u></u>	\$ <u><u>94,900.78</u></u>

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.

A. Square Feet: 26,000

B. General Construction Type: Exterior BrickFrame SteelNumber 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).
The Facility maintains a 20 bed wing for retirement residents not requiring skilled or intermediate care.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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	26,000	9/21/2015	\$ 185,364	1
2					2
3	TOTALS	26,000		\$ 185,364	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	70			2015	\$ 1,760,958	\$ 44,024	40	\$ 44,024	\$	\$ 55,030
5										
6										
7										
8										
	Improvement Type**									
9	Parking Lot Asphalt			2016	7,500	94	40	94		94
10	14 Air Conditioners			2016	13,986	544	15	544		544
11	Signage-Indoor			2016	7,566	126	15	126		126
12	Lobby Flooring			2016	122,540	2,042	15	2,042		2,042
13	Nurse Station Ceiling			2016	12,174	203	15	203		203
14	Interior Doors			2016	21,738	362	15	362		362
15	Sprinkler line replacements			2015	23,170	2,317	10	2,317		2,896
16	Sprinkler Piping			2015	20,450	818	25	818		1,023
17	Wiring for Internet Service			2015	11,080	2,216	5	2,216		2,955
18	Vinyl Tile and Coverbase - All Hallways			2015	6,015	601	10	601		752
19	Spa room remodel - tore down to studs, replaced all plumbing, drywall, tile			2016	22,126	369	15	369		369
20	fixtures and paint (only spa room in the facility)									
21	Shower Room Remodel - tore down to studs, replaced all plumbing, drywall,			2016	26,571	443	15	443		443
22	tile, fixtures, and paint (1 of 2)									
23	Lotus Private Shower Remodel - tore down to the studs, expanded, replaced			2016	69,463	1,158	15	1,158		1,158
24	all plumbing, drywall, tile, fixtures, minor electrical and paint (2 of 2)									
25	Physical Therapy Rooms Remodel - replace flooring, fixed damaged dry wall			2016	9,469	158	15	158		158
26	and painting									
27	Lotus Living, Dining Rooms - replace ceiling, electrical & paint			2016	53,413	890	15	890		890
28	Reception Remodel - replace flooring, replace/fix damaged drywall, paint			2016	6,096	102	15	102		102
29	Wall Sconces and Lighting upgrades -all hallways - electrical			2016	12,037	200	15	200		200
30										
31										
32										
33	HO Depreciation Allocation					5,441		5,441		
34										
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

Facility Name & ID Number Moweaqua Rehab & HCC

0053595

Report Period Beginning:

01/01/2016 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)		\$ 2,206,352	\$ 62,108		\$ 62,108	\$	\$ 69,347	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	\$364,217	\$51,745	\$51,745	\$	10	\$64,007	71
72	Current Year Purchases	69,693	4,858	4,858		Various	4,858	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$433,910	\$56,603	\$56,603	\$		\$68,865	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		Facility Auto	2015	\$43,227	\$8,645	\$8,645	\$	5	\$11,527	76
77										77
78										78
79										79
80	TOTALS			\$43,227	\$8,645	\$8,645	\$		\$11,527	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,868,853	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$127,356	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$127,356	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$149,739	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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: \$4,604
- Description: Plant and Copier (See WTB)
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-03	hrs	\$	4,839	\$ 78,395	\$	4,839	\$ 78,395	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		1,441	23,341		1,441	23,341	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		4,912	79,582	359	4,912	79,941	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				44,913		44,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					34,897	35,723		70,620	13
14	TOTAL			\$	11,192	\$ 216,215	\$ 80,995	11,192	\$ 297,210	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,967	\$ 23,584	1
2	Cash-Patient Deposits	7,145	7,145	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	657,618	657,618	3
4	Supply Inventory (priced at)	12,084	12,084	4
5	Short-Term Investments			5
6	Prepaid Insurance	115,909	115,909	6
7	Other Prepaid Expenses	14,859	14,859	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	68,973	68,973	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 887,555	\$ 900,172	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		185,364	13
14	Buildings, at Historical Cost	178,004	2,198,852	14
15	Leasehold Improvements, at Historical Cost	7,500	7,500	15
16	Equipment, at Historical Cost	112,920	477,137	16
17	Accumulated Depreciation (book methods)	(19,757)	(149,739)	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):	19,111	19,111	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 297,778	\$ 2,738,225	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,185,333	\$ 3,638,397	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,725	\$ 232,731	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,145	7,145	28
29	Short-Term Notes Payable	2,141,666	4,544,042	29
30	Accrued Salaries Payable	75,237	75,237	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,204	37,204	31
32	Accrued Real Estate Taxes(Sch.IX-B)	94,901	94,901	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)	\$ 2,509,878	\$ 4,991,260	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,509,878	\$ 4,991,260	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,324,545)	\$ (1,352,863)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,185,333	\$ 3,638,397	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (340,954)	1
2	Restatements (describe):		2
3	Paid In Capital	(75,786)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (416,740)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(907,805)	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)	\$ (907,805)	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)	\$ (1,324,545)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Moweaqua Rehab & HCC

0053595

Report Period Beginning: 01/01/2016

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	\$ 1,803,770	1
2	Discounts and Allowances for all Levels	(673,913)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,129,857	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	825,616	6
7	Oxygen	818	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 826,434	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,967	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	87,284	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,976	19
20	Radiology and X-Ray		20
21	Other Medical Services	89,466	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 189,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Vending Machine Revenue and Miscellaneous Income	24,278	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,278	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,170,289	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	533,891	31
32	Health Care	922,420	32
33	General Administration	841,563	33
	B. Capital Expense		
34	Ownership	202,886	34
	C. Ancillary Expense		
35	Special Cost Centers	475,266	35
36	Provider Participation Fee	102,068	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,078,094	40
41	Income before Income Taxes (line 30 minus line 40)**	(907,805)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (907,805)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 771,716	44
45	Private Pay - Net Inpatient Revenue	529,236	45
46	Medicare - Net Inpatient Revenue	(232,252)	46
47	Other-(specify) <u>Managed Care</u>	61,157	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,129,857	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Moweaqua Rehab & HCC# 0053595Report Period Beginning: 01/01/2016Ending: 12/31/2016

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	2,904	2,936	\$ 84,399	\$ 28.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,645	3,718	104,968	28.23	3
4	Licensed Practical Nurses	4,983	5,111	120,404	23.56	4
5	CNAs & Orderlies	21,704	22,789	273,763	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,231	2,284	25,233	11.05	10
11	Social Service Workers	1,924	2,100	39,944	19.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,829	10,256	103,948	10.14	15
16	Dishwashers					16
17	Maintenance Workers	2,541	2,581	47,728	18.49	17
18	Housekeepers	6,932	7,393	80,033	10.83	18
19	Laundry	2,564	2,678	24,369	9.10	19
20	Administrator	3,565	3,762	76,057	20.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,240	3,596	51,035	14.19	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	218	218	1,504	6.90	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	8,254	8,702	117,076	13.45	33
34	TOTAL (lines 1 - 33)	74,534	78,124	\$ 1,150,461 *	\$ 14.73	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	\$ 6,084	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,496	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,855	11-03	44
45	Social Service Consultant	Monthly	3,881	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,316		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	416	\$ 11,742	10-03	50
51	Licensed Practical Nurses	1,643	38,714	10-03	51
52	Certified Nurse Assistants/Aides	7,360	88,397	10-03	52
53	TOTAL (lines 50 - 52)	9,419	\$ 138,853		53

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Moweaqua Rehab & HCC

0053595

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ashley Blevins	Administrator	0	\$ 17,951
David Mabry	Administrator	0	12,773
Katina Beane	Administrator	0	22,576
Valerie Logsdon	Administrator	0	22,757
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,057

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
Polsinelli PC	Legal Fees	\$ 1,147
Lathrop & Gage LLP	Legal Fees	78
Daniel Maher Law Offices	Legal Fees	1,040
FR&R/Marcum LLP	Accounting Fees	4,876
PointClickCare Technologies Inc	Data Processing Fees	15,188
Kronos	Data Processing Fees	26,621
E-Health	Data Processing Fees	5,744
Tutera Health Care Services	Data Processing Fees	12,500
Other - Data Processing Fees	Data Processing Fees	725
Property Valuation Services	Property Tax Consulting	100
Pinnacle Quality Insight	Professional Services	2,026
Other - Professional Services	Professional Services	1,666
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 71,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 26,101
Unemployment Compensation Insurance	
FICA Taxes	117,224
Employee Health Insurance	19,538
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	14,360
TOTAL (agree to Schedule V, line 22, col.8)	\$ 177,223

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	\$ 5,679
Advertising: Employee Recruitment	7,457
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	14 138
Subscriptions	208
CLIA License	150
Shelby County Health Department	250
IL Healthcare Association Dues	4,620
Less: Public Relations Expense	(1,825)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,677

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,695
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,695

* 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?
If YES, give association name and amount.

Yes
IL Healthcare Association \$4,620

(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?

Yes
Yes

(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?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 6,562 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 102,068

(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.

No

(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?
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.

Yes

(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?

\$ Yes Indicate the amount. \$ 2,967

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

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.

No \$ N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%

d.

Have vehicle usage logs been maintained?

No

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes