

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 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	156	Skilled (SNF)	156	57,096	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	156	TOTALS	156	57,096	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,932	10,751	12,794	41,477	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,932	10,751	12,794	41,477	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.

Facility Name & ID Number

Lakeland Rehab & HCC

#0050971

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
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
45	GRAND TOTAL COST (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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Lakeland Rehab & HCC

ID# 0050971

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

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
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	(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	(666,969)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,002)	33,507	(583,222)	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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	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	(219,478)	45							

Facility Name & ID Number

Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	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	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 Tutera	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			Carlinville Rehabilitation & Health Care Center	Carlinville, 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

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			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

Facility Name & ID Number Lakeland Rehab & HCC

0050971 Report Period Beginning: 1/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Tutera Health Care Services
 Street Address 7611 State Line Road
 City / State / Zip Code Kansas City, Missouri 64114
 Phone Number (816-444-0900
 Fax Number (816-822-0081

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Management Fee - Operating	Direct Costs	47	\$ 10,144,719	\$ 7,332,933	8,493,834	\$ 460,795	1
2	30	Management Fee - Depreciation	Direct Costs	47	342,075		8,493,834	15,538	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		\$ 476,333	25

Facility Name & ID Number

Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

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

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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-11-020-019</u>	<u>Long Term Care Facility</u>	\$ <u>93,229.38</u>	\$ <u>93,229.38</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>93,229.38</u></u>	\$ <u><u>93,229.38</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 provide copies of their original **second installment tax bill.**

Facility Name & ID Number Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016 Ending:

12/31/2016

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Row 1: Land, 2010, \$612,285. Row 2: (blank). Row 3: TOTALS, \$612,285.

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	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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.

Facility Name & ID Number Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

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	76
77										77
78										78
79										79
80	TOTALS			\$ 57,587	\$ 11,517	\$ 11,517	\$		\$ 52,788	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)	\$ 6,877,009	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 324,309	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 324,309	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)	\$ 1,892,305	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lakeland Rehab & HCC

0050971

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

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

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	\$ _____

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: \$ 17,459 Description: Dietary, Laundry, 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

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2016**

(last day of reporting year)

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

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

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		Amount	
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) <u>Insurance</u>	(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.

Facility Name & ID Number Lakeland Rehab & HCC

0050971

Report Period Beginning:

1/01/2016

Ending:

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	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) <u>See Supplemental</u>	3,641	3,846	61,705	16.04	33
34	TOTAL (lines 1 - 33)	178,010	187,443	\$ 3,237,796 *	\$ 17.27	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	\$ 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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
William Wade	Admin	0	\$ 123,386	Workers' Compensation Insurance	\$ 64,904	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	4,557	
				FICA Taxes	265,930	Health Care Worker Background Check (Indicate # of checks performed 248)	2,480	
				Employee Health Insurance	67,270	IL Healthcare Association	9,306	
				Employee Meals		Dues & Subscriptions	8,853	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Benefits	19,197			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,386					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			Less: Public Relations Expense (4,541)	
Description			Amount				Non-allowable advertising ()	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8) \$ 22,645	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
Various	Legal Fees	\$ 40,612			\$	Out-of-State Travel \$		
Tutera Health Care Services	Data Processing	13,099						
Various	Data Processing	94,187						
Marcum, LLP	Accounting	8,731				In-State Travel		
Property Valuation Services	Compliance	100						
Curaspan	Data Processing	2,675						
Allscripts	General Prof Svcs	1,710				Seminar Expense 4,699		
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	TOTAL			Entertainment Expense () (agree to Sch. V, line 24, col. 8)	
							TOTAL \$ 4,699	

* Attach copy of IMRF notifications

**See instructions.

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 benefits 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