

Facility Name & ID Number Auburn Rehabilitation & Health Care Center

0047076 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 _____

	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	70	Skilled (SNF)	70	25,550	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	70	TOTALS	70	25,550	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	10,369	6,787	3,185	20,341	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,369	6,787	3,185	20,341	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.61%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/16/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/16/2005 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 1,690

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Auburn Rehabilitation & Health Care Center # 0047076 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		2,030	283,681	285,711		285,711		285,711		1
2	Food Purchase		15,844		15,844		15,844	(852)	14,992		2
3	Housekeeping		6,705	93,465	100,170		100,170		100,170		3
4	Laundry		7,315	62,310	69,625		69,625		69,625		4
5	Heat and Other Utilities			71,672	71,672		71,672		71,672		5
6	Maintenance	40,943	10,275	62,724	113,942		113,942		113,942		6
7	Other (specify):*										7
8	TOTAL General Services	40,943	42,169	573,852	656,964		656,964	(852)	656,112		8
	B. Health Care and Programs										
9	Medical Director					19,500	19,500		19,500		9
10	Nursing and Medical Records	1,252,622	91,597	65,629	1,409,848	(19,500)	1,390,348		1,390,348		10
10a	Therapy										10a
11	Activities	41,093	6,733	31,219	79,045		79,045		79,045		11
12	Social Services	37,827		5,251	43,078		43,078		43,078		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,331,542	98,330	102,099	1,531,971		1,531,971		1,531,971		16
	C. General Administration										
17	Administrative	92,330			92,330		92,330		92,330		17
18	Directors Fees										18
19	Professional Services			97,304	97,304		97,304	185,328	282,632		19
20	Dues, Fees, Subscriptions & Promotions			16,953	16,953		16,953	(1,696)	15,257		20
21	Clerical & General Office Expenses	82,377	20,550	299,895	402,822		402,822	(229,474)	173,348		21
22	Employee Benefits & Payroll Taxes			233,804	233,804		233,804		233,804		22
23	Inservice Training & Education			1,470	1,470		1,470		1,470		23
24	Travel and Seminar			6,782	6,782		6,782		6,782		24
25	Other Admin. Staff Transportation			5,529	5,529		5,529	(610)	4,919		25
26	Insurance-Prop.Liab.Malpractice			104,660	104,660		104,660		104,660		26
27	Other (specify):*										27
28	TOTAL General Administration	174,707	20,550	766,397	961,654		961,654	(46,452)	915,202		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,547,192	161,049	1,442,348	3,150,589		3,150,589	(47,304)	3,103,285		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

Auburn Rehabilitation & Health Care Center

#0047076

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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			11,419	11,419		11,419	66,370	77,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,692	2,692		2,692	(2,692)				32
33	Real Estate Taxes			20,889	20,889		20,889		20,889			33
34	Rent-Facility & Grounds			96,000	96,000		96,000	(96,000)				34
35	Rent-Equipment & Vehicles			10,573	10,573		10,573		10,573			35
36	Other (specify):* Mortgage Ins											36
37	TOTAL Ownership			141,573	141,573		141,573	(32,322)	109,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,727	412,975	538,702		538,702		538,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,560	151,560		151,560		151,560			42
43	Other (specify):* Marketing	38,136		13,148	51,284		51,284	(51,284)				43
44	TOTAL Special Cost Centers	38,136	125,727	577,683	741,546		741,546	(51,284)	690,262			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,585,328	286,776	2,161,604	4,033,708		4,033,708	(130,910)	3,902,798			45

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

Auburn Rehabilitation & Health Care Center

ID# 0047076

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Lobbying Dues	\$ (1,388)	20	1
2	PAC Dues	(308)	20	2
3	Marketing Salaries	(38,136)	43	3
4	Misc Income	(691)	21	4
5	Marketing Mileage	(610)	25	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(41,133)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Auburn Rehabilitation & Health Care Center# 0047076

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	(852)	0	0	0	0	0	0	0	0	0	0	(852)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(852)	0	0	0	0	0	0	0	0	0	0	(852)	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	0	185,328	0	0	0	0	0	0	0	0	185,328	19
20	Fees, Subscriptions & Promotions	(1,696)	0	0	0	0	0	0	0	0	0	0	(1,696)	20
21	Clerical & General Office Expenses	(50,163)	600	(179,911)	0	0	0	0	0	0	0	0	(229,474)	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	(610)	0	0	0	0	0	0	0	0	0	0	(610)	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	(52,469)	600	5,417	0	(46,452)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,321)	600	5,417	0	(47,304)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Auburn Rehabilitation & Health Care Center # 0047076 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,362	50,929	6,079	0	0	0	0	0	0	0	0	66,370	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,072)	3,380	0	0	0	0	0	0	0	0	0	(2,692)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(96,000)	0	0	0	0	0	0	0	0	0	(96,000)	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	3,290	(41,691)	6,079	0	(32,322)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(51,284)	0	0	0	0	0	0	0	0	0	0	(51,284)	43
44	TOTAL Special Cost Centers	(51,284)	0	0	0	0	0	0	0	0	0	0	(51,284)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(101,315)	(41,091)	11,496	0	(130,910)	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 Pg6-Supp		See Pg6-Supp		See Pg6-Supp		

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	21 Administrative	\$	JCT FLP Auburn LLC	0.00%	\$ 600	\$ 600	1
2	V	34 Rent	96,000	JCT FLP Auburn LLC	0.00%		(96,000)	2
3	V	32 Interest		JCT FLP Auburn LLC	0.00%	3,380	3,380	3
4	V	30 Depreciation		JCT FLP Auburn LLC	0.00%	50,929	50,929	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 96,000			\$ 54,909	\$ * (41,091)	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	26 Insurance	\$ 3,775	CarePlus Health Plans		\$ 3,775	\$	15
16	V	19 Management - Operating	36,987	Tutera Health Care Services	100.00%	222,315	185,328	16
17	V	30 Management - Depreciation		Tutera Health Care Services	100.00%	6,079	6,079	17
18	V	21 Management Fee	179,911	Tutera Health Care Services	100.00%		(179,911)	18
19	V	12 Social Services Wages	675	Carlinville Rehab & Healthcare		675		19
20	V	10 Nursing purchased services	265	Lakeland Rehabilitation & Health		265		20
21	V	21 Postage/Small Equip/Furniture	6,820	Walnut Creek Management Company, LLC		6,820		21
22	V	20 Employee Want Ads	1,527	Walnut Creek Management Company, LLC		1,527		22
23	V	24 Travel & Seminar	1,132	Walnut Creek Management Company, LLC		1,132		23
24	V	43 Advertising	476	Walnut Creek Management Company, LLC		476		24
25	V	26 Insurance	100,988	LTC Plus Insurance, Inc.		100,988		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		\$ 332,556			\$ 344,052	\$ * 11,496	39

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

Facility Name & ID Number Auburn Rehabilitation & Health Care Cente # 0047076 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Auburn Rehabilitation & Health Care Center

0047076

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	168,868,621	42	\$ 9,661,251	\$ 7,250,104	3,885,828	\$ 222,315	1
2	30	Management Fee - Depreciation	Direct Costs	168,868,621	42	264,186		3,885,828	6,079	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					\$ 9,925,437	\$ 7,250,104		\$ 228,394	25

Facility Name & ID Number Auburn Rehabilitation & Health Care Center

0047076

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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 LLC	X		Note Payable			\$ 479,000	\$	0.0075	\$ 622	1									
2	Tutera Group Inc	X		Note Payable			422,000	425,382		3,381	2									
3	JCT Capital	X		Note Payable			742,000	744,071	0.0100	2,070	3									
4	Interest Income Offset (to the extent of expense)																			
5										(6,073)	4									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related																			
							\$ 1,643,000	\$ 1,169,453		\$	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related																			
							\$	\$		\$	14									
15	TOTALS (line 9+line14)																			
							\$ 1,643,000	\$ 1,169,453		\$	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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 2016 report.		\$	<u>20,863</u>	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.)		\$	<u>19,071</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,792)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>22,681</u>	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.		\$	<u>20,889</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>18,637</u>	8
	2013	<u>19,001</u>	9
	2014	<u>20,837</u>	10
	2015	<u>20,862</u>	11
	2016	<u>19,071</u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$		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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,312 B. General Construction Type: Exterior Brick Frame Brick 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: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Long-Term Care, 2017, \$126,513. Row 3: TOTALS, \$126,513.

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	2017		\$ 1,012,103	\$ 34,362	27	\$ 34,362	\$	\$ 34,362
5									
6									
7									
8									
Improvement Type**									
9	2006 IMPROVEMENTS		2006	13,129	180	Various	180		12,171
10	2009 IMPROVEMENTS		2009	13,601	996	Various	996		8,593
11	2010 IMPROVEMENTS		2010	60,032	2,717	Various	2,717		44,199
12	2011 IMPROVEMENTS		2011	41,919	3,837	Various	3,837		26,123
13	HVAC REPLACEMENT		2014	19,728	1,973	10	1,973		6,741
14	SOUTH HALL SHOWER RENOVATION - tore down to studs, enlarged		2016	30,282	2,019	15	2,019		3,701
15	new materials, plumbing, drywall, paint and tile								
16	South Hall shower repair - plumbing/drywall/tile/paint		2017	22,796	1,357	7	1,357		1,357
17									
18	HOME OFFICE DEPRECIATION				6,079		6,079		
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
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

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	\$ 23,847	\$ 6,843	\$ 6,843	\$	Various	\$ 13,037	71
72	Current Year Purchases	148,510	17,087	17,087		Various	17,087	72
73	Fully Depreciated Assets	125,626	339	339		Various	125,626	73
74								74
75	TOTALS	\$ 297,983	\$ 24,269	\$ 24,269	\$		\$ 155,750	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		2009 Van	2009	\$ 35,900	\$	\$	\$	5	\$ 35,900	76
77										77
78										78
79										79
80	TOTALS			\$ 35,900	\$	\$	\$		\$ 35,900	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,673,986	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,789	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,789	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)	\$ 328,897	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 Auburn Rehabilitation & Health Care Center

0047076

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 10,573 Description: Dishwasher, Washer, 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	V39-03	hrs	\$	2,019	\$ 139,169	\$ 33	2,019	\$ 139,202	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		525	41,714		525	41,714	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		2,113	142,703	516	2,113	143,219	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescrpts				76,579		76,579	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 WTB</u>					89,389	48,599		137,988	13
14	TOTAL			\$	4,656	\$ 412,975	\$ 125,727	4,656	\$ 538,702	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 **12/31/2017**

(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	\$ 227,052	\$ 325,538	1
2	Cash-Patient Deposits	13,541	13,541	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	467,130	467,130	3
4	Supply Inventory (priced at)	8,096	8,096	4
5	Short-Term Investments			5
6	Prepaid Insurance	85,193	85,193	6
7	Other Prepaid Expenses	232,171	232,171	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	232	232	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,033,415	\$ 1,131,901	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		126,513	13
14	Buildings, at Historical Cost		1,012,103	14
15	Leasehold Improvements, at Historical Cost	201,486	201,486	15
16	Equipment, at Historical Cost	207,370	333,884	16
17	Accumulated Depreciation (book methods)	(277,968)	(328,897)	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 (spe PP&E Tax Adj)	(108,550)	(1,065,600)	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,338	\$ 279,489	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,055,753	\$ 1,411,390	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 294,814	\$ 294,814	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,541	13,541	28
29	Short-Term Notes Payable	744,071	1,169,454	29
30	Accrued Salaries Payable	93,433	93,433	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,239	19,239	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,071	19,071	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident and Employee Donations	1,102	1,102	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,185,271	\$ 1,610,654	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)	\$ 1,185,271	\$ 1,610,654	46
47	TOTAL EQUITY(page 18, line 24)	\$ (129,518)	\$ (199,264)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,055,753	\$ 1,411,390	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 382,525	1
2	Restatements (describe):		2
3	Distributions	(83,217)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 299,308	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(428,826)	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)	\$ (428,826)	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)	\$ (129,518)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Auburn Rehabilitation & Health Care Center

0047076

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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	\$ 3,297,557	1
2	Discounts and Allowances for all Levels	(1,924,859)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,372,698	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,865,975	6
7	Oxygen	832	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,866,807	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	852	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	159,804	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,513	19
20	Radiology and X-Ray		20
21	Other Medical Services	179,703	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 355,872	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,814	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,814	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	691	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 691	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,604,882	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	656,964	31
32	Health Care	1,531,971	32
33	General Administration	961,654	33
B. Capital Expense			
34	Ownership	141,573	34
C. Ancillary Expense			
35	Special Cost Centers	589,986	35
36	Provider Participation Fee	151,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,033,708	40
41	Income before Income Taxes (line 30 minus line 40)**	(428,826)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (428,826)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,554,908	44
45	Private Pay - Net Inpatient Revenue	291,357	45
46	Medicare - Net Inpatient Revenue	(773,568)	46
47	Other-(specify) Managed Care	300,001	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,372,698	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 Auburn Rehabilitation & Health Care Center

0047076

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	4,217	4,427	\$ 125,203	\$ 28.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,662	12,054	350,081	29.04	3
4	Licensed Practical Nurses	10,971	11,518	244,784	21.25	4
5	CNAs & Orderlies	41,004	42,898	516,590	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,156	3,679	41,093	11.17	10
11	Social Service Workers	2,100	2,270	37,827	16.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,089	2,144	40,943	19.10	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,032	2,236	92,330	41.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,282	4,489	82,377	18.35	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	887	1,067	15,964	14.96	31
32	Other Health Care(specify)			0		32
33	Other(specify) <u>Marketing</u>	2,014	2,051	38,136	18.59	33
34	TOTAL (lines 1 - 33)	84,414	88,833	\$ 1,585,328 *	\$ 17.85	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	\$ 283,628	V01-3	35
36	Medical Director	Monthly	19,500	V09-5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,122	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	31,219	V11-3	44
45	Social Service Consultant	Monthly	5,251	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 346,720		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	105	2,668	V10-3	51
52	Certified Nurse Assistants/Aides	640	16,262	V10-3	52
53	TOTAL (lines 50 - 52)	745	\$ 18,930		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	
Curtis Nelson	Administrator	0	\$ 12,913	Workers' Compensation Insurance	\$ 40,834	IDPH License Fee	\$ 3,980	
Cheryl Vittorio	Administrator	0	4,015	Unemployment Compensation Insurance		Advertising: Employee Recruitment	4,538	
Lori McKinnon	Administrator	0	75,402	FICA Taxes	137,862	Health Care Worker Background Check (Indicate # of checks performed <u>107</u>)	1,073	
				Employee Health Insurance	46,618	Patient Background Checks		
				Employee Meals		IHCA PAC	308	
				Illinois Municipal Retirement Fund (IMRF)*		IL Health Care Association	4,620	
				Other Benefits	8,490	IL Secretary of State	250	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,330			Sangamon County Dept of Public Health	861	
B. Administrative - Other						Other Misc	1,323	
Description			Amount			Less: Public Relations Expense	(1,696)	
N/A			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 233,804	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,257	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal		\$ 18,527	N/A		\$	Out-of-State Travel	\$
Brown Hay & Stephens LLP	Legal		3,713					
CliftonLarsonAllen LLP	Accounting/Cost Report		7,785					
Walnut Creek Mgmt Co, LLC	Data Processing		36,983				In-State Travel	
Ability Network Inc	Data Processing		4,778					
PointClickCare Technologies	Data Processing		18,942					
Aegis Therapies	Professional Services		2,674				Seminar Expense	6,782
Allscripts Healthcare LLC	Professional Services		1,780					
Memorial Physician Services	Professional Services		21					
Pinnacle Quality Insight	Professional Services		1,553					
Property Valuation Services	Professional Services		548				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 97,304	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,782

* 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 Health Care Association \$4,620
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,419 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. \$ 151,560
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 852
- (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? 100%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ No
- (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