FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0050997

Facility Name: Marion Rehab and Nrsg Ctr

Address: 1301 East Deyoung (Number) Marion (City) 62959 (Zip Code)

County: Williamson

Telephone Number: (708) 236-0000 **Fax #** (708) 236-0001

HFS ID Number:

Date of Initial License for Current Owners: 06/01/10

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Alan Irni
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	125	Skilled (SNF)	125	45,625	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	125	TOTALS	125	45,625	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,603	4,662	5,699	33,964	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,603	4,662	5,699	33,964	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.44%

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)
N/A

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 06/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 5,699

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,391	16,000	7,025	191,416		191,416	(127)	191,289			1
2	Food Purchase		186,642		186,642		186,642		186,642			2
3	Housekeeping	116,955	17,887		134,842		134,842		134,842			3
4	Laundry	69,447	12,767		82,214		82,214		82,214			4
5	Heat and Other Utilities			178,962	178,962		178,962	1,934	180,896			5
6	Maintenance	56,232	23,456	15,578	95,266		95,266	255	95,521			6
7	Other (specify):*											7
8	TOTAL General Services	411,025	256,752	201,565	869,342		869,342	2,062	871,404			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,611,986	148,115	40,042	1,800,143		1,800,143		1,800,143			10
10a	Therapy			765,181	765,181		765,181		765,181			10a
11	Activities	59,112	4,063		63,175		63,175		63,175			11
12	Social Services	49,575		6,076	55,651		55,651		55,651			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			4,193	4,193		4,193		4,193			15
16	TOTAL Health Care and Programs	1,720,673	152,178	820,292	2,693,143		2,693,143		2,693,143			16
	C. General Administration											
17	Administrative	91,782			91,782		91,782		91,782			17
18	Directors Fees											18
19	Professional Services			310,471	310,471		310,471	(298,363)	12,108			19
20	Dues, Fees, Subscriptions & Promotions			10,832	10,832		10,832	426	11,258			20
21	Clerical & General Office Expenses	95,155	31,366	49,830	176,351		176,351	171,329	347,680			21
22	Employee Benefits & Payroll Taxes			326,177	326,177		326,177	32,687	358,864			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,359	7,359		7,359	9,128	16,487			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			206,718	206,718		206,718	809	207,527			26
27	Other (specify):*											27
28	TOTAL General Administration	186,937	31,366	911,387	1,129,690		1,129,690	(83,984)	1,045,706			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,318,635	440,296	1,933,244	4,692,175		4,692,175	(81,922)	4,610,253			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 Marion Rehab and Nrsg Ctr #0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,811	51,811		51,811	64,070	115,881			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			22,088	22,088		22,088	(610)	21,478			32
33	Real Estate Taxes			56,728	56,728		56,728		56,728			33
34	Rent-Facility & Grounds			784,808	784,808		784,808	10,025	794,833			34
35	Rent-Equipment & Vehicles							1,086	1,086			35
36	Other (specify):*											36
37	TOTAL Ownership			916,250	916,250		916,250	74,571	990,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,659	1,659		1,659		1,659			38
39	Ancillary Service Centers		267,431		267,431		267,431		267,431			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,558	243,558		243,558		243,558			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		267,431	245,217	512,648		512,648		512,648			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,318,635	707,727	3,094,711	6,121,073		6,121,073	(7,351)	6,113,722			45

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	61,132	30		9
10	Interest and Other Investment Income	(610)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(127)	1		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				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				24
25	Fund Raising, Advertising and Promotional	(19,186)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,684)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (475)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,876)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,876)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (7,351)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Marion Rehab and Nrsg Ctr

ID# **0050997**

Report Period Beginning: **1/1/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Revenue	$ (41,684)	21	1
2				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
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**	(41,684)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marion Rehab and Nrsg Ctr **#** 0050997 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	(127)	0	0	0	0	0	0	0	0	0	0	(127)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	1,934	0	0	0	0	0	0	0	0	0	1,934	5
6	Maintenance	0	255	0	0	0	0	0	0	0	0	0	255	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(127)	2,189	0	0	0	0	0	0	0	0	0	2,062	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	(298,363)	0	0	0	0	0	0	0	0	0	(298,363)	19
20	Fees, Subscriptions & Promotions	0	426	0	0	0	0	0	0	0	0	0	426	20
21	Clerical & General Office Expenses	(60,870)	232,199	0	0	0	0	0	0	0	0	0	171,329	21
22	Employee Benefits & Payroll Taxes	0	32,687	0	0	0	0	0	0	0	0	0	32,687	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,128	0	0	0	0	0	0	0	0	0	9,128	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	809	0	0	0	0	0	0	0	0	0	809	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(60,870)	(23,114)	0	0	0	0	0	0	0	0	0	(83,984)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,997)	(20,925)	0	0	0	0	0	0	0	0	0	(81,922)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	61,132	2,938	0	0	0	0	0	0	0	0	0	64,070	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(610)	0	0	0	0	0	0	0	0	0	0	(610)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	10,025	0	0	0	0	0	0	0	0	0	10,025	34
35	Rent-Equipment & Vehicles	0	1,086	0	0	0	0	0	0	0	0	0	1,086	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	60,522	14,049	0	0	0	0	0	0	0	0	0	74,571	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(475)	(6,876)	0	0	0	0	0	0	0	0	0	(7,351)	45

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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
Steven Blisko	60.00%	Alton Rehab & Nursing	Alton	Senior Management	Skokie	Management Co.
A&F General Partnership	35.00%	Anna Rehab & Nursing	Anna			
Ted Lerman	5.00%	Chester Rehab & Nursing	Chester			
		Carbondale Rehab & Nursing	Carbondale			
		Cobden Rehab & Nursing	Cobden			
		Columbia Rehab & Nursing	Columbia			
		Herrin Rehab & Nursing	Herrin			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Senior Healthcare Management		$ 1,934	$ 1,934	1
2	V	6	Repairs		Senior Healthcare Management		255	255	2
3	V	19	Professional Services	300,000	Senior Healthcare Management		1,637	(298,363)	3
4	V	20	Licenses & Fees		Senior Healthcare Management		426	426	4
5	V	21	Office Supplies		Senior Healthcare Management		4,492	4,492	5
6	V	21	Office Expense		Senior Healthcare Management		4,082	4,082	6
7	V	21	Payroll		Senior Healthcare Management		223,625	223,625	7
8	V	22	Employee Benefits		Senior Healthcare Management		32,687	32,687	8
9	V	24	Travel/Seminar		Senior Healthcare Management		9,128	9,128	9
10	V	26	Insurance		Senior Healthcare Management		809	809	10
11	V	30	Depreciation Expense		Senior Healthcare Management		2,938	2,938	11
12	V	34	Rent Expense		Senior Healthcare Management		10,025	10,025	12
13	V	35	Equipment Lease		Senior Healthcare Management		1,086	1,086	13
14	Total			$ 300,000			$ 293,124	$ * (6,876)	14

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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			Midwest Rehab & Respiratory Center	Belleville				1
2			Ridgway Rehab & Nursing	Ridgway				2
3			Integrity Healthcare of Godfrey	Godfrey				3
4			Integrity Healthcare of Smithton	Smithton				4
5			Integrity Healthcare of Wood River	Wood River				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 Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										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					$	$		$	25

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Working Capital	None	8/4/15	1,500,000	900,000	8/4/16	4.5000	22,088	6
7												7
8												8
9	TOTAL Facility Related						$ 1,500,000	$ 900,000			$ 22,088	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 900,000			$ 22,088	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** 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.)**

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (14,246)	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.)		$ 57,300	2
3. Under or (over) accrual (line 2 minus line 1).		$ 71,546	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (14,818)	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.		$ 56,728	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	58,516	8
	2011	60,122	9
	2012	54,334	10
	2013	55,340	11
	2014	57,300	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marion Rehab and Nrsg Ctr COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0050997

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-17-151-001	Nursing Facility	$ 57,300.10	$ 57,300.10
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,300.10	$ 57,300.10

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,500 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 12,225 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 815 4. Dates Incurred: Prior to 06/01/10

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Windows & Doors			2010	5,700	146	39	146		815	9
10	Humidifier - NOT USED FOR CAPITAL RATE INCREASE			2010	676	17	39	17		96	10
11	Heat & Cool System - NOT USED FOR CAPITAL RATE INCREASE			2010	2,434	62	39	62		347	11
12	Heating System - NOT USED FOR CAPITAL RATE INCREASE			2010	5,949	153	39	153		853	12
13	Heating System - NOT USED FOR CAPITAL RATE INCREASE			2010	1,082	28	39	28		155	13
14	Fire Sprinklers			2011	10,018	257	39	257		1,263	14
15	Fire Sprinklers			2011	75,795	1,943	39	1,943		8,745	15
16	Roof Repairs			2011	9,750	250	39	250		1,167	16
17	Panelling			2011	9,398	241	39	241		1,064	17
18	Exterior work: columns, access panel, sconces, soffit			2011	30,000	769	39	769		3,461	18
19	Lobby:Demolition, Lighting/Electrical, Painting, Flooring,										19
20	Trim, Millwork			2011	101,615	2,605	39	2,605		11,726	20
21	Wall covering & ceiling tiles in Admissions office			2011	7,735	198	39	198		892	21
22	Nurses Station: wallpaper, reface desk, lighting, painting			2011	21,087	541	39	541		2,433	22
23	Flooring & Painting Vestibule			2011	5,687	146	39	146		657	23
24	Lighting, wallpaper, floor tile, kitchen cabinets for diniing			2011	31,194	800	39	800		3,600	24
25	Additional parking spots/ asphalt			2011	61,666	1,581	39	1,581		7,115	25
26	Rewire failing door closures			2011	3,800	97	39	97		438	26
27	Refinish doors			2011	16,500	423	39	423		1,904	27
28	New ceiling tiles & basket lighting fixtures			2011	16,000	410	39	410		1,846	28
29	New windows & glass door			2011	27,000	692	39	692		3,115	29
30	Install EIFS and paint			2011	68,000	1,744	39	1,744		7,847	30
31	Custom exterior sign			2011	19,000	487	39	487		2,192	31
32	PTAC units			2011	38,000	974	39	974		4,384	32
33	New kitchen tile			2011	10,800	277	39	277		1,246	33
34	Steel Valve			2011	2,300	59	39	59		265	34
35	Hot water Boilers Repair			2011	2,000	51	39	51		231	35
36	Roof engineering fee			2011	4,500	115	39	115		519	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Resident Rooms: door handles, ceiling tiles, paint, flooring,		$	$		$	$	$	37
38	lighting fixtures	2011	138,348	3,547	39	3,547		15,962	38
39	Corridors: handrails, signs, doors, ceiling tiles, lighting	2011	130,900	3,356	39	3,356		15,102	39
40	Windows & Painting of Laundry Room	2011	3,300	85	39	85		382	40
41	HVACs	2011	32,400	831	39	831		3,739	41
42	Landscaping	2011	12,500	321	39	321		1,444	42
43	Drainage	2011	4,600	118	39	118		531	43
44	Custom laminate nurses station	2011	16,900	433	39	433		1,949	44
45	Restrooms: Molding, chair rail, door, tile, paint, toliets, mirror	2011	22,000	564	39	564		2,538	45
46	Whirlpool Tub, plumbing, wall tiles	2011	12,000	308	39	308		1,386	46
47	Shower room: door, tile, paint, shower stalls, bathtub, lights	2011	55,000	1,410	39	1,410		6,345	47
48	Patio: concrete, doors, drainage	2011	41,600	1,067	39	1,067		4,801	48
49	Dining: Molding, chair rail, ceiling tiles, wallcoverng, signs	2011	50,535	1,296	39	1,296		5,832	49
50	New doors and walls in medicine storage room	2011	6,000	154	39	154		693	50
51	Storage Room: new wall, door and paint	2011	5,500	141	39	141		635	51
52	Toliets, sinks, mirrors, lighting grab bars in resd bathrooms	2011	30,000	769	39	769		3,461	52
53	Roof	2011	83,000	2,128	39	2,128		9,576	53
54	Toliets, sinks, mirrors, lighting grab bars in resd bathrooms	2011	10,000	256	39	256		1,152	54
55	Call Bell System and Wander Mangagment System	2011	61,000	1,564	39	1,564		7,038	55
56	Med room& MOP : closet door, sink, counter, lighting, paint	2011	5,700	146	39	146		657	56
57	Bathroom: flooring, sink, toliet, lighting, grab bars. Paint	2011	4,100	105	39	105		473	57
58	Concrete patio	2011	6,300	162	39	162		729	58
59	Sink room: tile, backsplash, paint, countertops, cabinets	2011	4,000	103	39	103		463	59
60	Woodlock Kick Plates	2011	7,900	203	39	203		913	60
61	Refinish nurse station, quartz countertop	2011	5,300	136	39	136		612	61
62	Flooring for vestibule	2011	2,300	59	39	59		265	62
63	Seating Areas: door, paint, lighting, ceiling tile, drywall, flooring	2011	8,100	208	39	208		936	63
64	Water heater and intallation	2013	2,836	73	39	73		194	64
65	Wiring for nurse stations and kiosks	2013	20,763	532	39	532		1,241	65
66									66
67	5 ton Gas Electric Rooftop Units	2014	10,768		39	276	276	1,077	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,381,336	$ 35,143		$ 35,419	$ 276	$ 158,501	70

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,381,336	$ 35,143		$ 35,419	$ 276	$ 158,501	1
2	Install new Duro-Last roofing system	2015	148,950	1,749	39	2,864	1,115	1,749	2
3	Build 30 x 40 x 8ft metal barn	2015	15,500	182	39	298	116	182	3
4	309 sq yrds of hot-mix asphalt and pouring	2015	6,475	76	39	111	35	76	4
5	Repair damage to roof	2015	1,383	16	39	24	8	16	5
6	Troubleshoot and fix Wonderguard call bell system	2015	1,575	19	39	24	5	19	6
7	Repair kitchen drain line, tie in new drains, pour concrete	2015	23,800	280	39	51	(229)	280	7
8	Labor, parts, excavating, disposal fees to repair water line	2015	3,566	42	39	15	(27)	42	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	TOTAL (lines 1 thru 33)		$ 1,582,585	$ 37,507		$ 38,806	$ 1,299	$ 160,865	34

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 332,151	$ 9,030	$ 71,801	$ 62,771	5	$ 313,552	71
72	Current Year Purchases	52,742	5,274	5,274		5	5,274	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 384,893	$ 14,304	$ 77,075	$ 62,771		$ 318,826	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,967,478	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,811	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,881	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,070	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 479,691	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 Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Southern Illinois Healthcare Realty, LLC
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. [X] 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:	1995	68	5/15/10	$ 784,808	20		3
4	Additions	2001	57					4
5								5
6								6
7	TOTAL		125		$ 784,808 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: [X] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning 06/01/10
    Ending 05/31/30

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

	Fiscal Year Ending	Annual Rent
12.	12/31/16	$ 806,933
13.	12/31/17	$ 830,410
14.	12/31/18	$ 854,686

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
    (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.

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	5,810	$ 331,168	$	5,810	$ 331,168	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,757	114,160		1,757	114,160	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,541	319,853		6,541	319,853	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				246,667		246,667	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radiology & Lab	39-2					20,764		20,764	12
13	Other (specify):									13
14	TOTAL			$	14,108	$ 765,181	$ 267,431	14,108	$ 1,032,612	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.

STATE OF ILLINOIS

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,639	$ 7,639	1
2	Cash-Patient Deposits	(1,619)	(1,619)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,169,492	2,169,492	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(58,356)	(58,356)	6
7	Other Prepaid Expenses	(22,500)	(22,500)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,094,656	$ 2,094,656	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,571,816	1,571,816	15
16	Equipment, at Historical Cost	395,660	395,660	16
17	Accumulated Depreciation (book methods)	(479,688)	(479,688)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,550)	(4,550)	20
21	Restricted Funds	119,528	119,528	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,614,991	$ 1,614,991	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,709,647	$ 3,709,647	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 976,055	$ 976,055	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,414	140,414	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,380	11,380	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	900,000	900,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,027,849	$ 2,027,849	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,027,849	$ 2,027,849	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,681,798	$ 1,681,798	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,709,647	$ 3,709,647	48

*(See instructions.)

Facility Name & ID Number Marion Rehab and Nrsg Ctr **#** 0050997 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,470,998	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,470,998	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	535,800	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	(325,000)	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)**	$ 210,800	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,681,798	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,300,602	1
2	Discounts and Allowances for all Levels	(953,443)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,347,159	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,043,514	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,043,514	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	204,555	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,149	19
20	Radiology and X-Ray	5,202	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 223,906	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	610	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 610	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Revenue	41,684	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41,684	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,656,873	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	869,341	31
32	Health Care	2,693,144	32
33	General Administration	1,129,691	33
	B. Capital Expense		
34	Ownership	916,249	34
	C. Ancillary Expense		
35	Special Cost Centers	269,090	35
36	Provider Participation Fee	243,558	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,121,073	40
41	**Income before Income Taxes (line 30 minus line 40)****	535,800	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 535,800	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,015,076	44
45	Private Pay - Net Inpatient Revenue	868,548	45
46	Medicare - Net Inpatient Revenue	2,295,749	46
47	Other-(specify)	167,786	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,347,159	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,711	1,841	$ 57,745	$ 31.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,094	6,300	147,121	23.35	3
4	Licensed Practical Nurses	24,540	26,026	475,593	18.27	4
5	CNAs & Orderlies	70,704	74,345	807,567	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,041	6,405	59,112	9.23	9
10	Activity Assistants					10
11	Social Service Workers	3,709	4,002	49,575	12.39	11
12	Dietician	15,363	16,308	168,391	10.33	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,533	3,760	56,232	14.96	17
18	Housekeepers	12,314	13,021	116,955	8.98	18
19	Laundry	7,482	8,076	69,447	8.60	19
20	Administrator	1,879	2,103	91,782	43.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,372	3,687	44,273	12.01	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	780	821	7,610	9.27	31
32	Other Health C: MDS	5,146	5,523	116,351	21.07	32
33	Other(specify) Admissions	1,892	2,059	50,881	24.71	33
34	TOTAL (lines 1 - 33)	164,560	174,277	$ 2,318,635 *	$ 13.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	201	$ 7,025	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	647	22,640	10-3	38
39	Pharmacist Consultant	84	4,193	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	174	6,076	12-3	45
46	Other(specify) MDS Consultant	497	17,401	10-3	46
47	HR Corp Compliance	185	9,274	21-3	47
48					48
49	TOTAL (lines 35 - 48)	1,788	$ 66,609		49

C. CONTRACT NURSES

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

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Morgan	Administrator		$ 64,062
Elizabeth Dunn	Administrator		27,720
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,782

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Summers, Compton, Wells	Legal Fees	$ 1,755
Bradley Associates	Accounting Fees	7,466
Johnson Goldberg	Accounting Fees	1,250
Senior Healthcare	Mgmt/Professional Fees	300,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 310,471

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,844
Unemployment Compensation Insurance	76,772
FICA Taxes	185,587
Employee Health Insurance	44,499
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	8,162
TOTAL (agree to Schedule V, line 22, col.8)	$ 358,864

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IL Council	8,290
Annual Report Fee	250
Secretary of State	277
Registered Agent Fee	25
Various	426
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,258

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	6,142
Mileage	1,217
Mgmt Co. Gas and Lodging	9,128
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,487

**See instructions.

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Marion Rehab and Nrsg Ctr # 0050997 Report Period Beginning: 1/1/15 Ending: 12/31/15

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. **Illinois Council - 8,290**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,655** 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? **X** YES ____ 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **243,558**
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? **N/A**

(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? **N/A** 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. $ **None** 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? **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. $ **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 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.