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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0046540

Facility Name: Edwardsville Nsg & Rehab Ctr

Address: 401 St Mary Drive (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: 618-692-1330 **Fax #** 815-338-9478

HFS ID Number:

Date of Initial License for Current Owners: 1/1/04

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 1/1/2016 to 12/31/2016 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) Mike Sorells
(Title) Chief Financial Officer

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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	120	Skilled (SNF)	120	43,920	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	120	TOTALS	120	43,920	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	16,912	7,391	6,927	31,230	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,912	7,391	6,927	31,230	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.11%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 01/01/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2004 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,683

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	222,269	12,122	10,425	244,816		244,816	(263)	244,553			1
2	Food Purchase		225,615		225,615		225,615		225,615			2
3	Housekeeping	146,833	24,498		171,331		171,331		171,331			3
4	Laundry	49,918	6,545		56,463		56,463		56,463			4
5	Heat and Other Utilities			144,232	144,232		144,232		144,232			5
6	Maintenance	59,038	35,739	35,760	130,537		130,537	988	131,525			6
7	Other (specify):*											7
8	TOTAL General Services	478,058	304,519	190,417	972,994		972,994	725	973,719			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	1,980,596	177,355	36,421	2,194,372		2,194,372	27,926	2,222,298			10
10a	Therapy		5,402	423,684	429,086		429,086	(71,595)	357,491			10a
11	Activities	64,582	4,053	3,665	72,300		72,300		72,300			11
12	Social Services	50,507	73	2,469	53,049		53,049		53,049			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,095,685	186,883	508,239	2,790,807		2,790,807	(43,669)	2,747,138			16
	C. General Administration											
17	Administrative	86,997			86,997		86,997		86,997			17
18	Directors Fees											18
19	Professional Services			169,344	169,344		169,344	9,838	179,182			19
20	Dues, Fees, Subscriptions & Promotions			5,904	5,904		5,904	987	6,891			20
21	Clerical & General Office Expenses	258,970	26,614	124,228	409,812		409,812	360,742	770,554			21
22	Employee Benefits & Payroll Taxes			581,067	581,067		581,067	39,160	620,227			22
23	Inservice Training & Education			9,416	9,416		9,416		9,416			23
24	Travel and Seminar			13,059	13,059		13,059	33,818	46,877			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,306	100,306		100,306	361	100,667			26
27	Other (specify):*											27
28	TOTAL General Administration	345,967	26,614	1,003,324	1,375,905		1,375,905	444,906	1,820,811			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,919,710	518,016	1,701,980	5,139,706		5,139,706	401,962	5,541,668			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 Edwardsville Nsg & Rehab Ctr #0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			50,092	50,092		50,092	4,718	54,810			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							2,951	2,951			32
33	Real Estate Taxes			78,081	78,081		78,081		78,081			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(220,414)	19,586			34
35	Rent-Equipment & Vehicles			102,218	102,218		102,218		102,218			35
36	Other (specify):*											36
37	**TOTAL Ownership**			470,391	470,391		470,391	(212,745)	257,646			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,309	4,309		4,309		4,309			38
39	Ancillary Service Centers		248,834	27,510	276,344		276,344		276,344			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,554	193,554		193,554		193,554			42
43	Other (specify):* **Bad Debt**			163,498	163,498		163,498	(163,498)				43
44	**TOTAL Special Cost Centers**		248,834	388,871	637,705		637,705	(163,498)	474,207			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,919,710	766,850	2,561,242	6,247,802		6,247,802	25,719	6,273,521			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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2,177	30		9
10	Interest and Other Investment Income	(109)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(263)	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	(26,331)	21		18
19	Entertainment				19
20	Contributions	70	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(163,498)	43		24
25	Fund Raising, Advertising and Promotional	(12,384)	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	(96,195)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (296,533)		$	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)	322,252	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 322,252		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 25,719		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Edwardsville Nsg & Rehab Ctr

ID# 0046540

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (88,594)	21	1
2	Misc. Exp. PY Adjustments	(609)	21	2
3	Vending Machine Income	(2,896)	21	3
4	Marketing Supplies	(3,524)	21	4
5	Gifts and Flowers	(572)	21	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**	(96,195)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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	(263)	0	0	0	0	0	0	0	0	0	0	(263)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	988	0	0	0	0	0	0	0	0	988	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(263)	0	988	0	0	0	0	0	0	0	0	725	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	27,926	0	0	0	0	0	0	0	0	27,926	10
10a	Therapy	0	(71,595)	0	0	0	0	0	0	0	0	0	(71,595)	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	(71,595)	27,926	0	0	0	0	0	0	0	0	(43,669)	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	9,838	0	0	0	0	0	0	0	0	9,838	19
20	Fees, Subscriptions & Promotions	0	0	987	0	0	0	0	0	0	0	0	987	20
21	Clerical & General Office Expenses	(134,840)	409,554	86,028	0	0	0	0	0	0	0	0	360,742	21
22	Employee Benefits & Payroll Taxes	0	0	39,160	0	0	0	0	0	0	0	0	39,160	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	33,818	0	0	0	0	0	0	0	0	33,818	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	0	361	0	0	0	0	0	0	0	0	361	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(134,840)	409,554	170,192	0	0	0	0	0	0	0	0	444,906	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(135,103)	337,959	199,106	0	0	0	0	0	0	0	0	401,962	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr **#** 0046540 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,177	0	2,541	0	0	0	0	0	0	0	0	4,718	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(109)	160	2,900	0	0	0	0	0	0	0	0	2,951	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(220,414)	0	0	0	0	0	0	0	0	0	(220,414)	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**	2,068	(220,254)	5,441	0	0	0	0	0	0	0	0	(212,745)	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):*	(163,498)	0	0	0	0	0	0	0	0	0	0	(163,498)	43
44	**TOTAL Special Cost Centers**	(163,498)	0	0	0	0	0	0	0	0	0	0	(163,498)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(296,533)	117,705	204,547	0	0	0	0	0	0	0	0	25,719	45

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg6 - Supplemental		See Pg6 - Supplemental		See Pg6 - Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	10a	Physical Therapy	$ 164,329	Tru Rehab, LLC	100.00%	$ 136,530	$ (27,799)	1
2	V	10a	Occupational Therapy	166,974	Tru Rehab, LLC	100.00%	138,725	(28,249)	2
3	V	10a	Speech Therapy	55,905	Tru Rehab, LLC	100.00%	46,448	(9,457)	3
4	V	10a	Therapy Management Fee	36,000	Tru Rehab, LLC	100.00%	29,910	(6,090)	4
5	V								5
6	V	21	Clerical and General		Davis Ide HCP		409,554	409,554	6
7	V	32	Interest		Davis Ide HCP		160	160	7
8	V	34	Rent	240,000	Davis Ide HCP		19,586	(220,414)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 663,208			$ 780,913	$ * 117,705	14

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	6	Maintenance	$	Ide Management Group, LLC	100.00%	$ 988	$ 988	15
16	V	10	Nursing		Ide Management Group, LLC	100.00%	27,926	27,926	16
17	V	19	Professional Fees		Ide Management Group, LLC	100.00%	9,838	9,838	17
18	V	20	Dues, Fees, Subscriptions		Ide Management Group, LLC	100.00%	987	987	18
19	V	21	Clerical and General		Ide Management Group, LLC	100.00%	146,028	146,028	19
20	V	22	Employee Benefits		Ide Management Group, LLC	100.00%	39,160	39,160	20
21	V	24	Travel and Seminar		Ide Management Group, LLC	100.00%	33,818	33,818	21
22	V	26	Insurance		Ide Management Group, LLC	100.00%	361	361	22
23	V	30	Depreciation		Ide Management Group, LLC	100.00%	2,541	2,541	23
24	V	32	Interest		Ide Management Group, LLC	100.00%	2,900	2,900	24
25	V								25
26	V	21	Management Fees	60,000	Ide Management Group, LLC	100.00%		(60,000)	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			$ 60,000			$ 264,547	$ * 204,547	39

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mark Ide	100%	Cathedral Health Care Center	Jasper, IN	Ide Mgmt. Group	Indianapolis, IN	Management	1
2			Chesterton Manor	Chesterton, IN	TruRehab, LLC	Vincennes, IN	Rehab Therapies	2
3			Cloverleaf Healthcare	Knightsville, IN	Davis-Ide HC Prop.	Indianapolis, IN	Property Mgmt.	3
4			Colonial Nursing & Rehab	Crown Point, IN				4
5			Kendallville Manor	Kendallville, IN				5
6			Madison Health Care Center	Indianapolis, IN				6
7			Oak Village	Oaktown, IN				7
8			River Terrace Retirement Community	Bluffton, IN				8
9			Silver Memories Health Care	Versailles, IN				9
10			Warsaw Meadows	Warsaw, IN				10
11			Woodland Manor	Elkhart, IN				11
12			Yorktown Manor	Yorktown, IN				12
13			Edwardsville Nursing and Rehabilitation	Edwardsville, IL				13
14			Newton Care Center	Newton, IL				14
15			North Logan Health Care Center	Danville, IL				15
16			Paris Healthcare Center	Paris, IL				16
17			University Nursing and Rehab	Edwardsville, IL				17
18			Countryside Health Care Center	Sioux City, IA				18
19			Eagle Point Health Care Center	Clinton, IA				19
20			Keosauqua Health Care Center	Keosauqua, IA				20
21			Keota Health Care Center	Keota, IA				21
22			Newton Health Care Center	Newton, IA				22
23			Sigourney Health Care	Sigourney, IA				23
24			Urbandale Health Care Center	Urbandale, IA				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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	Mark Ide	Shareholder	Administrative	100.00	See Attached	2.4	6.00	Alloc Salary	$ 20,987	21-7	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	$ 20,987		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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Ide Management Group, LLC
Street Address: 4521 Independence Square
City / State / Zip Code: Indianapolis, IN 46203
Phone Number: ((317) 744-9148
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	6	Maintenance	Inpatient Days	520,848	21	$ 16,474	$	31,231	$ 988	1
2	10	Nursing	Inpatient Days	520,848	21	465,727	465,727	31,231	27,926	2
3	19	Professional Fees	Inpatient Days	520,848	21	164,068		31,231	9,838	3
4	20	Dues, Fees, Subscriptions	Inpatient Days	520,848	21	16,459		31,231	987	4
5	21	Clerical and General	Inpatient Days	520,848	21	2,435,345	2,155,175	31,231	146,028	5
6	22	Employee Benefits	Inpatient Days	520,848	21	653,083		31,231	39,160	6
7	24	Travel and Seminar	Inpatient Days	520,848	21	563,986		31,231	33,818	7
8	26	Insurance	Inpatient Days	520,848	21	6,020		31,231	361	8
9	30	Depreciation	Inpatient Days	520,848	21	42,379		31,231	2,541	9
10	32	Interest	Inpatient Days	520,848	21	48,362		31,231	2,900	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					$ 4,411,903	$ 2,620,902		$ 264,547	25

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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 Edwardsville Nsg & Rehab Ctr **#** 0046540 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 68,419	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.)		$ 79,022	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,603	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,478	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.		$ 78,081	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	76,061	8
	2012	77,580	9
	2013	78,298	10
	2014	78,290	11
	2015	79,022	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Edwardsville Nsg & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046540

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-1-16-07-00-000-019.003	Nursing Home	$ 79,022.16	$ 79,022.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 79,022.16	$ 79,022.16

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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 [X] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 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											9
10	Electrical Wiring			2004	1,730	64	27	64		827	10
11	Doors			2004	1,194	44	27	44		545	11
12	Evap Coil & Compressor			2005	1,715	100	15	114	14	1,371	12
13	Sidewalk			2006	4,455	266	15	297	31	3,312	13
14	Kammermeyer Remove Concrete			2006	2,000	117	15	133	16	1,481	14
15	Sidewalk			2006	407	23	15	27	4	300	15
16	Sidewalk			2006	1,441	82	15	96	14	1,063	16
17	A/C Unit Rooftop			2007	2,500	149	15	167	18	1,710	17
18	Roof			2008	2,100	110	20	105	(5)	865	18
19	Shower Stalls			2008	1,500	56	27	56		450	19
20	Shower Stalls			2008	1,691	63	27	63		502	20
21	Cabinets & Counter Top			2009	657	22	15	44	22	158	21
22	Cabinets & Counter Tops			2009	678	23	15	45	22	163	22
23	Leasehold Improvements			2010	3,610	134	27	134		840	23
24	Electric Wiring			2011	1,421	53	27	53		313	24
25	Doors			2011	999	37	27	37		220	25
26	Evap Coil & Compressor			2011	962	60	15	64	4	426	26
27	Sidewalk			2011	2,777	173	15	185	12	1,232	27
28	Kammermyer Remove Concrete			2011	1,247	78	15	83	5	553	28
29	Sidewalk			2011	254	16	15	17	1	112	29
30	Sidewalk			2011	898	56	15	60	4	398	30
31	A/C Unit Roof Top			2011	1,732	108	15	115	7	768	31
32	Excavating			2011	1,723	107	15	115	8	764	32
33	Roof			2011	865	46	20	43	(3)	304	33
34	Rebuild Shower Stalls			2011	1,384	51	27	51		305	34
35	Rebuild Shower Stalls			2011	1,566	58	27	58		345	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Cabinets & Counters	2011	$ 304	$ 20	15	$ 20	$	$ 112	37
38	Cabinets & Counter Top	2011	314	21	15	21		116	38
39	Leasehold Improvements	2011	3,583	92	39	92		553	39
40	Concrete	2011	7,357	490	15	490		7,317	40
41	Excavating	2012	2,488	249	10	249		1,257	41
42	Adj Per Audit	2012	7,326	733	10	733		5,398	42
43	Roof Replacement	2013	22,324	2,232	10	2,232		7,520	43
44	Trash Enclosure	2013	3,604	240	15	240		749	44
45	Water Heater 90 Gallon	2013	4,800	480	10	480		1,495	45
46	Shower Renovation C Hall	2013	9,000	450	20	450		1,403	46
47	Hot Water Heater	2014	1,690	169	10	169		470	47
48	Remodel Entry Bathroom	2014	1,400	70	20	70		195	48
49	New flat roof	2014	50,399	5,039	10	5,039		12,731	49
50	Concrete patio w/ privacy fence 12x16	2014	2,700	180	15	180		394	50
51	Sprinkler Head Replacement	2015	1,021	51	20	51		90	51
52	Outdoor Signage	2015	3,731	187	20	187		298	52
53	3 80 Gallon Water Heaters	2015	20,199	1,010	20	1,010		1,531	53
54	Flooring	2015	41,700	2,084	20	2,084		2,809	54
55	Flooring	2015	11,550	578	20	578		730	55
56	Doors	2016	2,664	22	20	133	111	22	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 239,660	$ 16,493		$ 16,778	$ 285	$ 64,517	70

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 233,812	$ 21,489	$ 23,381	$ 1,892	5-20	$ 153,721	71
72	Current Year Purchases	35,186	3,610	3,610		5-7	3,610	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 268,998	$ 25,099	$ 26,991	$ 1,892		$ 157,331	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		2012 Ford E350 Goshen Coach	2015	$ 42,500	$ 8,500	$ 8,500	$	5	$ 14,167	76
77										77
78										78
79										79
80	TOTALS			$ 42,500	$ 8,500	$ 8,500	$		$ 14,167	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)	$ 551,158	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,092	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,269	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,177	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 236,015	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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors

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:		120	11/1/03	$ 240,000	21	20	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 240,000 **			7

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

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

10. Effective dates of current rental agreement:
Beginning 11/1/03
Ending 12/31/24

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2017	$ 260,532
13.	12/31/2018	$ 268,348
14.	12/31/2019	$ 276,399

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: $ 102,218 Description:
(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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	3,388	$ 166,974	$	3,388	$ 166,974	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,120	55,905		1,120	55,905	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,443	164,329		3,443	164,329	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				248,834		248,834	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-3					10,930		10,930	12
13	Other (specify): Lab	39-3					16,580		16,580	13
14	TOTAL			$	7,951	$ 387,208	$ 276,344	7,951	$ 663,552	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.

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr **#** 0046540 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,524	$	1
2	Cash-Patient Deposits	72,892		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,852,253		3
4	Supply Inventory (priced at)	10,595		4
5	Short-Term Investments			5
6	Prepaid Insurance	36,687		6
7	Other Prepaid Expenses	59,998		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,045,949	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	95,919		14
15	Leasehold Improvements, at Historical Cost	143,741		15
16	Equipment, at Historical Cost	311,498		16
17	Accumulated Depreciation (book methods)	(236,015)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 315,143	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,361,092	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,605,173	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,138		30
31	Accrued Taxes Payable (excluding real estate taxes)	94,565		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,081		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Resident Trust Fund Liability	72,893		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,867,850	$	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)**	$ 2,867,850	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (506,758)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,361,092	$	48

***(See instructions.)**

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,137,971)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	2,211,373	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,402	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(580,160)	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)**	$ (580,160)	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)**	$ (506,758)	24 *

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,001,453	1
2	Discounts and Allowances for all Levels	(321,926)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,679,527	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	755,668	6
7	Oxygen	50,563	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 806,231	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	158,953	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,310	19
20	Radiology and X-Ray	7,530	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 178,793	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	109	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 109	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	2,896	28
28a	Misc. Revenue	86	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,982	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,667,642	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	972,994	31
32	Health Care	2,790,807	32
33	General Administration	1,375,905	33
	B. Capital Expense		
34	Ownership	470,391	34
	C. Ancillary Expense		
35	Special Cost Centers	444,151	35
36	Provider Participation Fee	193,554	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,247,802	40
41	**Income before Income Taxes (line 30 minus line 40)****	(580,160)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (580,160)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,609,248	44
45	Private Pay - Net Inpatient Revenue	407,439	45
46	Medicare - Net Inpatient Revenue	566,211	46
47	Other-(specify) Net Inpatient Revenue	96,629	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,679,527	49

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

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

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,271	2,448	$ 83,828	$ 34.24	1
2	Assistant Director of Nursing	1,263	1,381	49,631	35.94	2
3	Registered Nurses	10,242	10,632	320,493	30.14	3
4	Licensed Practical Nurses	25,491	27,267	641,358	23.52	4
5	CNAs & Orderlies	61,656	65,876	854,297	12.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,365	4,732	64,582	13.65	9
10	Activity Assistants					10
11	Social Service Workers	3,292	3,319	50,507	15.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,171	20,148	222,269	11.03	15
16	Dishwashers					16
17	Maintenance Workers	3,160	3,278	59,038	18.01	17
18	Housekeepers	11,484	12,557	146,833	11.69	18
19	Laundry	5,022	5,296	49,918	9.43	19
20	Administrator	1,283	1,384	86,997	62.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,430	4,929	170,377	34.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,797	1,915	30,989	16.18	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	3,409	4,022	88,593	22.03	33
34	TOTAL (lines 1 - 33)	158,336	169,184	$ 2,919,710 *	$ 17.26	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	298	$ 10,425	1.3	35
36	Medical Director	Monthly	42,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	298	$ 52,425		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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jessica Fritz	Administrator		$ 44,371
Tanya Rommerskirchen	Administrator		42,626
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,997

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
Hepler Broom LLC	Legal	$ 3,576
Drewry Simmons Vornehm, LLC	Legal	440
Marvin R Steinke, Attorney at Law P	Legal	100
Saikley Garrison Colombo & Barney,	Legal	319
BKD	Accounting	7,255
Parrish Consulting	Professional	13,152
Outcome Services of IL	Professional	5,537
Integrated Resources Mgmt	Professional	78,965
Ide Mgmt Group	Professional/Mgmt	60,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 169,344

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,033
Unemployment Compensation Insurance	47,706
FICA Taxes	215,496
Employee Health Insurance	196,968
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	2,643
Human Resources	5,221
Ide Mgmt Group	39,160
TOTAL (agree to Schedule V, line 22, col.8)	$ 620,227

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	5,379
License and Permits	525
Ide Mgmt Group	987
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,891

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	7,670
Seminar Expense	
Hotel	5,389
Ide Mgmt Group	33,818
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 46,877

**See instructions.

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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? **NO**
If YES, give association name and amount. **N/A**

(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? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,128** Line **10.2**

(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. $ **193,554**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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 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