	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: 0046276

Facility Name: Metropolis Rehab & HCC

Address: 2299 Metropolis St (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2634 Fax # (618) 524-2507

HFS ID Number:

Date of Initial License for Current Owners: 7/1/2003

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] 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: Kevin Wellen Telephone Number: 314-925-4446

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 1/01/2016 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)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Kevin Wellen, CPA Director
	(Firm Name & Address)	CliftonLarsonAllen, LLP 600 Washington Ave. Suite 1800, St. Louis, MO 63101
	(Telephone)	314-925-4446 Fax # 314-925-4350

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 Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1 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	101	Skilled (SNF)	101	36,966	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	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,215	6,798	5,660	22,673	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,215	6,798	5,660	22,673	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.33%

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 7/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 101 and days of care provided 3,784

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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		3,999	383,887	387,886		387,886		387,886			1
2	Food Purchase		18,161		18,161		18,161	(1,553)	16,608			2
3	Housekeeping		10,176	96,570	106,746		106,746		106,746			3
4	Laundry		6,310	58,478	64,788		64,788		64,788			4
5	Heat and Other Utilities			162,627	162,627		162,627		162,627			5
6	Maintenance	51,403	18,542	89,049	158,994		158,994	27,438	186,432			6
7	Other (specify):*											7
8	**TOTAL General Services**	51,403	57,188	790,611	899,202		899,202	25,885	925,087			8
	B. Health Care and Programs											
9	Medical Director					6,000	6,000		6,000			9
10	Nursing and Medical Records	1,414,372	64,018	58,995	1,537,385	(6,000)	1,531,385		1,531,385			10
10a	Therapy											10a
11	Activities	28,758	14,629	7,846	51,233		51,233		51,233			11
12	Social Services	30,809		3,596	34,405		34,405		34,405			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,473,939	78,647	70,437	1,623,023		1,623,023		1,623,023			16
	C. General Administration											
17	Administrative	84,873			84,873		84,873		84,873			17
18	Directors Fees											18
19	Professional Services			75,772	75,772		75,772	219,741	295,513			19
20	Dues, Fees, Subscriptions & Promotions			17,486	17,486		17,486	(3,479)	14,007			20
21	Clerical & General Office Expenses	83,110	14,175	456,453	553,738		553,738	(420,346)	133,392			21
22	Employee Benefits & Payroll Taxes			273,690	273,690		273,690		273,690			22
23	Inservice Training & Education					211	211		211			23
24	Travel and Seminar			5,650	5,650	(211)	5,439	(81)	5,358			24
25	Other Admin. Staff Transportation			21,921	21,921		21,921	(8,342)	13,579			25
26	Insurance-Prop.Liab.Malpractice			159,711	159,711		159,711	(5,146)	154,565			26
27	Other (specify):*											27
28	**TOTAL General Administration**	167,983	14,175	1,010,683	1,192,841		1,192,841	(217,653)	975,188			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,693,325	150,010	1,871,731	3,715,066		3,715,066	(191,768)	3,523,298			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 Metropolis Rehab & HCC #0046276 **Report Period Beginning:** 1/01/2016 **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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,474	29,474		29,474	107,873	137,347			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,281	15,281		15,281	87,126	102,407			32
33	Real Estate Taxes			48,000	48,000		48,000	(12,710)	35,290			33
34	Rent-Facility & Grounds			248,277	248,277		248,277	(248,277)				34
35	Rent-Equipment & Vehicles			19,462	19,462		19,462		19,462			35
36	Other (specify):* Mortgage Ins							19,494	19,494			36
37	TOTAL Ownership			360,494	360,494		360,494	(46,494)	314,000			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,499	449,779	658,278		658,278		658,278			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,430	177,430		177,430		177,430			42
43	Other (specify):* Marketing	53,583		18,853	72,436		72,436	(72,436)				43
44	TOTAL Special Cost Centers	53,583	208,499	646,062	908,144		908,144	(72,436)	835,708			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,746,908	358,509	2,878,287	4,983,704		4,983,704	(310,698)	4,673,006			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 Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(894)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25,000)	21		18
19	Entertainment	(11,452)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,783)	21		24
25	Fund Raising, Advertising and Promotional	(18,853)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(67,512)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,510)		$	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)			34
35	Other- Attach Schedule	(124,188)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (124,188)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (310,698)		37

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

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

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

Metropolis Rehab & HCC

ID# 0046276

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (1,368)	21	1
2	Marketing Mileage	(8,342)	25	2
3	Marketing seminars	(81)	24	3
4	Chamber of Commerce Dues	(300)	20	4
5	Annual Report	(250)	20	5
6	PAC Dues	(2,929)	20	6
7	Marketing Salary	(53,583)	43	7
8	Vending Machine Revenues	(659)	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,512)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,553)	0	0	0	0	0	0	0	0	0	0	(1,553)	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	27,438	0	0	0	0	0	0	0	0	0	27,438	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,553)	27,438	0	0	0	0	0	0	0	0	0	25,885	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	8,073	211,668	0	0	0	0	0	0	0	0	219,741	19
20	Fees, Subscriptions & Promotions	(3,479)	0	0	0	0	0	0	0	0	0	0	(3,479)	20
21	Clerical & General Office Expenses	(100,603)	0	(319,743)	0	0	0	0	0	0	0	0	(420,346)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(81)	0	0	0	0	0	0	0	0	0	0	(81)	24
25	Other Admin. Staff Transportation	(8,342)	0	0	0	0	0	0	0	0	0	0	(8,342)	25
26	Insurance-Prop.Liab.Malpractice	0	(5,146)	0	0	0	0	0	0	0	0	0	(5,146)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(112,505)	2,927	(108,075)	0	0	0	0	0	0	0	0	(217,653)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,058)	30,365	(108,075)	0	0	0	0	0	0	0	0	(191,768)	29

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	Capital Expense 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	0	99,475	8,398	0	0	0	0	0	0	0	0	107,873	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16)	87,142	0	0	0	0	0	0	0	0	0	87,126	32
33	Real Estate Taxes	0	(12,710)	0	0	0	0	0	0	0	0	0	(12,710)	33
34	Rent-Facility & Grounds	0	(248,277)	0	0	0	0	0	0	0	0	0	(248,277)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	19,494	0	0	0	0	0	0	0	0	0	19,494	36
37	**TOTAL Ownership**	(16)	(54,876)	8,398	0	0	0	0	0	0	0	0	(46,494)	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):*	(72,436)	0	0	0	0	0	0	0	0	0	0	(72,436)	43
44	**TOTAL Special Cost Centers**	(72,436)	0	0	0	0	0	0	0	0	0	0	(72,436)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(186,510)	(24,511)	(99,677)	0	0	0	0	0	0	0	0	(310,698)	45

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board Listing at PG6-Supp		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	34	Rent	$ 248,277	TI-Metropolis	100.00%	$	$ (248,277)	1
2	V	32	Interest		TI-Metropolis	100.00%	87,142	87,142	2
3	V	19	Legal		TI-Metropolis	100.00%	450	450	3
4	V	19	Accounting		TI-Metropolis	100.00%	7,623	7,623	4
5	V	36	Mortgage Interest Premium		TI-Metropolis	100.00%	19,216	19,216	5
6	V	30	Depreciation		TI-Metropolis	100.00%	99,475	99,475	6
7	V	36	Amortization		TI-Metropolis	100.00%	278	278	7
8	V	6	Maintenance		TI-Metropolis	100.00%	27,438	27,438	8
9	V	33	Real Estate Taxes	48,000	TI-Metropolis	100.00%	35,290	(12,710)	9
10	V	26	Insurance	15,240	TI-Metropolis	100.00%	10,094	(5,146)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 311,517			$ 287,006	$ * (24,511)	14

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

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Management Fees - Operating	$ 219,243	Tutera Health Care Services	100.00%	$	$ (219,243)	15
16	V	19	Management Fees - Operating	37,405	Tutera Health Care Services	100.00%	249,073	211,668	16
17	V	30	Management Fees - Depreciation		Tutera Health Care Services	100.00%	8,398	8,398	17
18	V	21	Postage & Delivery Services	3,000	Walnut Creek Management Company LLC		3,000		18
19	V	10	Nursing purchased services	834	Coulterville Rehabilitation & Health Center		834		19
20	V	21	RP Asset Management Fees	100,500	JCT Capital LLC			(100,500)	20
21	V	26	Insurance	142,315	LTC Plus Insurance Inc.		142,315		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 503,297			$ 403,620	$ * (99,677)	39

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

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph Tutera	100%	Auburn Rehabilitation & Health Care Center	Auburn, IL	TI - Metropolis	Metropolis, IL	Building Company	1
2			Windsor Rehabilitation & Health Care Center	Terrell, TX	Walnut Creek Manage	Kansas City, MO	Management Co	2
3			Bethany Rehabilitation & Health Care Center	DeKalb, IL	Tutera Health Care Se	Kansas City, MO	Management Co	3
4			Carlinville Rehabilitation & Health Care Center	Carlinville, IL	LTC Services, LLC	Kansas City, MO	Management Co	4
5			Crystal Pines Rehabilitation & Health Care Cen	Crystal Lake, IL	Walnut Creek New En	Kansas City, MO	Management Co	5
6			Dixon Rehabilitation & Health Care Center	Dixon, IL	Columbia 7611 LLC	Kansas City, MO	Building Company	6
7			Fair Oaks Rehabilitation & Health Care Center	South Beloit, IL	The Atriums Senior Li	Overland Park, KS	Independent/Assiste	7
8			Hamilton Memorial Rehabilitation & Health Ca	McLeansboro, IL	Carnegie Village Senio	Belton, MO	Independent/Assiste	8
9			Highland Rehabilitation & Health Care Center	Kansas City, MO	Continua Home Healtl	Kansas City, MO	Home Health	9
10			Hillsboro Rehabilitation & Health Care Center	Hillsboro, IL	Continua Hospice KS	Kansas	Hospice	10
11			Lakeland Rehabilitation & Health Care Center	Effingham, IL	Continua Hospice MO	Missouri	Assisted Living	11
12			Mattoon Rehabilitation & Health Care Center	Matoon, IL	Country Gardens Assi	Muskogee, OK	Assisted Living	12
13			Meridian Rehabilitation & Health Care Center	Wichita, KS	Gentilly Gardens Seni	Statesboro, GA	Assisted Living	13
14			Monterey Park Rehabilitation & Health Care C	Independence, MO	Lamar Court Assisted	Overland Park, KS	Assisted Living	14
15			Montgomery Chilren's Specialty Center	Montgomery, AL	Oakley Courts Assiste	Freeport, IL	Assisted Living	15
16			Moweaqua Rehabilitation & Health Care Cente	Moweaqua, IL	Rose Estates Assisted I	Overland Park, KS	Assisted Living	16
17			The Pine Rehabilitation & Health Care Center	Lansing, MI	Stratford Commons M	Overland Park, KS	Memory Care	17
18			The Plaza Rehabilitation & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, KS	Independent/Assiste	18
19			Charlton Place Rehabilitation & Health Care Ce	Deatsville, AL	Wesley Court Assisted	Boiling Springs, SC	Assisted Living	19
20			Startford Commons Rehabilitation & Health Ca	Overland Park, KS	Willow Place Assisted	Laurinburg, NC	Assisted Living	20
21			Westridge Gardens Rehabilitation & Health Ca	Raytown, MO				21
22			Willow Care Rehabilitation & Health Care Cent	Hannibal, MO				22
23			Woodlawn Rehabilitation & Health Care Cente	Wichita, KS				23
24			Holly Hill House	Sulphur, LA				24
25			Rosewood Nurisng Center	Lake Charles, LA				25
26			Beautiful Savior	Belton, MO				26
27			Coulterville Rehabilitation & Health Care Cente	Coulterville, IL				27
28			Greenfield Manor	Greenfield, IA				28
29			Griswold Care Center	Griswold, IA				29
30			Close to Home	Matthews, MO				30

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Holly Ridge	Dexter, MO				1
2			Ramsey Creek	Scott City, MO				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	19	Management Fee - Operating	Direct Costs	186,997,591	47	$ 10,144,719	$ 7,332,933	4,591,174	$ 249,074	1
2	30	Management Fee - Depreciation	Direct Costs	186,997,591	47	342,075		4,591,174	8,399	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,486,794	$ 7,332,933		$ 257,473	25

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Tutera Investments		X	Note Payable			$	$ 2,841,895			$ 15,281	1
2	TI - Metropolis LLC		X	Mortgage Payable HUD Loan				3,541,989			87,142	2
3	Interest Income										(16)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,383,884			$ 102,407	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 6,383,884			$ 102,407	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 19,216 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2015 report.	$	34,415	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.)	$	34,852	2
3. Under or (over) accrual (line 2 minus line 1).	$	437	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,853	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.	$	35,290	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2011	31,315	8
	2012	31,184	9
	2013	33,434	10
	2014	34,415	11
	2015	34,852	12

Line	FOR BHF USE ONLY		Line
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 Metropolis Rehab & HCC COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0046276

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen

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

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

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

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	05-36-300-006	Long Term Care Facility	$ 34,852.48	$ 34,852.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,852.48	$ 34,852.48

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 Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,793 B. General Construction Type: Exterior Brick Frame Block 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? [ ] 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	42,793	2003	$ 285,485	1
2					2
3	TOTALS	42,793		$ 285,485	3

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 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	101		2003	1965	$ 2,226,786	$ 55,670	35	$ 55,670	$	$ 751,540	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Seal/Coat (TI Metropolis LLC)			2010	4,465	447	10	447		3,125	9
10	Parking Lot Repair (TI Metropolis LLC)			2013	15,650	1,043	15	1,043		3,652	10
11	Generator (TI Metropolis LLC)			2009	6,563		5			6,563	11
12	Water Heater (TI Mettropolis LLC) - Disposed in 2016			2009		54	10	54			12
13	Roof Repair (TI Metropolis LLC)			2009	3,935	393	10	393		3,588	13
14	New Facia and Paint (TI Metropolis LLC)			2009	9,500	950	10	950		6,729	14
15	Dining Room Flooring (TI Metropolis LLC)			2010	25,038	2,504	10	2,504		16,275	15
16	Sprinkler Heads/Door Closers (TI Metropolis LLC)			2010	1,682	240	7	240		1,522	16
17	Chiller Rebuild (TI Metropolis LLC)			2010	13,293	1,329	10	1,329		8,419	17
18	Electrical Upgrades (TI Metropolis LLC)			2010	5,978	598	10	598		3,786	18
19	Walk in Freezer (TI Metropolis LLC)			2010	8,022	802	10	802		4,947	19
20	100 Hall Heater Repair (TI Metropolis LLC)			2010	2,315	232	10	232		1,408	20
21	Laundry Doors (TI Metropolis LLC)			2010	985	66	15	66		416	21
22	Freezer Installitaion & removal (TI Metropolis LLC)			2011	2,500	250	10	250		1,500	22
23	Installation of Condensing Unit (TI Metropolis LLC)			2011	8,900	593	15	593		3,362	23
24	Emergency Generator (TI Metropolis LLC)			2011	22,200	1,110	20	1,110		6,197	24
25	Roof Repair (TI Metropolis LLC)			2012	38,438	1,922	20	1,922		8,809	25
26	Sprinkler System (TI Metropolis LLC)			2013	146,799	9,787	15	9,787		35,069	26
27	Exterior Painting (TI Metropolis LLC)			2015	7,370	1,404	7	1,404		1,404	27
28	Rooftop HVAC (TI Metropolis LLC)			2016	16,995	566	10	566		566	28
29	Doors & Frames Main, Serice & Employee Entrance (TI Metropoli			2016	9,842	273	15	273		273	29
30	Hot Water Heater Storage Tank (TI Metropolis LLC)			2016	43,135	719	20	719		719	30
31	Entrance Canopy (TI Metropilis LLC)			2016	9,185	102	15	102		102	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic Door Closures	2003	$ 1,185	$ 79	15	$ 79	$	$ 1,053	37
38	Chremical Monitor for Chiller	2003	1,683		5			1,683	38
39	Door Kickplates	2004	4,897		10			4,897	39
40	Nurses Station	2004	4,090	273	15	273		3,431	40
41	Ton Chiller	2004	34,400	1,720	20	1,720		20,927	41
42	Versico Roofing System	2005	29,700		10			29,700	42
43	Remodel Patient Rooms	2005	113,689		10			113,689	43
44	Painting Bedrooms and Bathrooms	2005	9,055		5			9,055	44
45	Carpet Front Entrance & Patio Deck	2006	2,795		5			2,795	45
46	Nurse Call System	2007	2,132		5			2,132	46
47	Hall Renovations	2012	229,200	11,460	10	11,460		164,260	47
48									48
49	HO Depreciation Allocation			8,398		8,398			49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,062,402	$ 102,984		$ 102,984	$	$ 1,223,593	70

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

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 209,785	$ 21,578	$ 21,578	$	10	$ 158,189	71
72	Current Year Purchases	29,169	2,209	2,209		10	2,209	72
73	Fully Depreciated Assets	421,862					421,862	73
74								74
75	TOTALS	$ 660,816	$ 23,787	$ 23,787	$		$ 582,260	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		Ford Goshen Bus	8/25/2015	$ 43,709	$ 10,576	$ 10,576	$	4	$ 13,984	76
77										77
78										78
79										79
80	TOTALS			$ 43,709	$ 10,576	$ 10,576	$		$ 13,984	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)	$ 4,052,412	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,347	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,819,837	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 19,462 Description: Dietary, Laundry, Plant, Copier & nursing (see WTB)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V39-3	hrs	$	9,130	$ 147,902	$	9,130	$ 147,902	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		3,434	55,633		3,434	55,633	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		12,899	208,808	514	12,899	209,322	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				134,818		134,818	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					37,436	73,167		110,603	13
14	TOTAL			$	25,463	$ 449,779	$ 208,499	25,463	$ 658,278	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 Metropolis Rehab & HCC # 0046276 Report Period Beginning: 1/01/2016 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	$ 149,040	$ 191,340	1
2	Cash-Patient Deposits	20,460	20,460	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	781,964	781,964	3
4	Supply Inventory (priced at)	7,312	7,312	4
5	Short-Term Investments			5
6	Prepaid Insurance	146,421	157,817	6
7	Other Prepaid Expenses	90,106	90,106	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	22,441	216,841	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,217,744	$ 1,465,840	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		285,485	13
14	Buildings, at Historical Cost		2,609,460	14
15	Leasehold Improvements, at Historical Cost	432,826	452,941	15
16	Equipment, at Historical Cost	176,222	704,526	16
17	Accumulated Depreciation (book methods)	(493,605)	(1,819,837)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other Long-Term Assets	55,642	139,666	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 171,085	$ 2,372,241	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,388,829	$ 3,838,081	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 235,549	$ 235,549	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,460	20,460	28
29	Short-Term Notes Payable	2,841,895	2,841,895	29
30	Accrued Salaries Payable	97,539	97,539	30
31	Accrued Taxes Payable (excluding real estate taxes)	44,144	44,144	31
32	Accrued Real Estate Taxes(Sch.IX-B)		34,852	32
33	Accrued Interest Payable		7,192	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,093	2,093	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,241,680	$ 3,283,724	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,451,989	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)**	$	$ 3,451,989	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,241,680	$ 6,735,713	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,852,851)	$ (2,897,632)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,388,829	$ 3,838,081	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,299,206)	1
2	Restatements (describe):		2
3	Prior year adjustments	43,362	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,255,844)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(597,007)	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)**	$ (597,007)	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)**	$ (1,852,851)	24 *

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

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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	$ 3,000,487	1
2	Discounts and Allowances for all Levels	(1,132,750)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,867,737	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,188,683	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,188,683	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	659	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	268,762	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,709	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,763	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 328,893	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	1,368	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,368	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,386,697	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	899,202	31
32	Health Care	1,623,023	32
33	General Administration	1,192,841	33
	B. Capital Expense		
34	Ownership	360,494	34
	C. Ancillary Expense		
35	Special Cost Centers	730,714	35
36	Provider Participation Fee	177,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,983,704	40
41	**Income before Income Taxes (line 30 minus line 40)****	(597,007)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (597,007)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,439,191	44
45	Private Pay - Net Inpatient Revenue	980,105	45
46	Medicare - Net Inpatient Revenue	(372,666)	46
47	Other-(specify) Insurance	(178,893)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,867,737	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.**

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,216	3,491	$ 113,108	$ 32.40	1
2	Assistant Director of Nursing	0	0			2
3	Registered Nurses	14,775	15,733	459,230	29.19	3
4	Licensed Practical Nurses	11,961	12,528	286,061	22.83	4
5	CNAs & Orderlies	44,559	47,711	545,732	11.44	5
6	CNA Trainees	0	0			6
7	Licensed Therapist	0	0			7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	0	0			9
10	Activity Assistants	1,833	1,849	28,758	15.55	10
11	Social Service Workers	1,559	1,641	30,809	18.77	11
12	Dietician	0	0			12
13	Food Service Supervisor	0	0			13
14	Head Cook	0	0			14
15	Cook Helpers/Assistants	0	0			15
16	Dishwashers	0	0			16
17	Maintenance Workers	3,123	3,185	51,403	16.14	17
18	Housekeepers	0	0			18
19	Laundry	0	0			19
20	Administrator	1,952	2,000	84,873	42.44	20
21	Assistant Administrator	0	0			21
22	Other Administrative	0	0			22
23	Office Manager	0	0			23
24	Clerical	4,430	4,710	83,110	17.65	24
25	Vocational Instruction	0	0			25
26	Academic Instruction	0	0			26
27	Medical Director	0	0			27
28	Qualified MR Prof. (QMRP)	0	0			28
29	Resident Services Coordinator	0	0			29
30	Habilitation Aides (DD Homes)	0	0			30
31	Medical Records	789	981	10,241	10.44	31
32	Other Health Care(specify)	0	0			32
33	Other(specify) Marketing	2,620	2,780	53,583	19.27	33
34	TOTAL (lines 1 - 33)	90,817	96,609	$ 1,746,908 *	$ 18.08	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 383,887	V01-3	35
36	Medical Director	Monthly	6,000	V9-3	36
37	Medical Records Consultant	Monthly	975	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,829	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	7,846	V11-3	44
45	Social Service Consultant	Monthly	3,596	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 407,133		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$ 3,878	V10-3	50
51	Licensed Practical Nurses		6,144	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 10,022		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Emling, Robert	Admin	0	$ 84,873
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,873

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
Danile Maher Law Offices	Legal Fees	$ 4,600
Tutera Health Care Services	Data Processing	30,000
Various	Data Processing	30,375
Marcum, LLP	Accounting	7,000
Property Valuation Services	Compliance	100
Allscripts	General Prof Svcs	1,710
Pinnacle Quality Insight	Customer Satisfaction Survey	1,987
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 75,772

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,264
Unemployment Compensation Insurance	0
FICA Taxes	157,789
Employee Health Insurance	39,785
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	29,852
TOTAL (agree to Schedule V, line 22, col.8)	$ 273,690

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	4,371
Health Care Worker Background Check (Indicate # of checks performed 273)	2,738
IL Healthcare Association	7,416
Dues & Subscriptions	811
Other Licenses	160
Less: Public Relations Expense	(3,479)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,007

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,358
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,358

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Healthcare Association $7,416**

(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? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,439** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **177,430**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 1**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees