FOR BHF USE

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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: 0046557

Facility Name: University Nsg & Rehab Ctr

Address: 1095 University Dr (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: 618-656-1081 **Fax #** 618-656-7083

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 University Nsg & Rehab Ctr # 0046557 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	122	Skilled (SNF)	122	44,652	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	122	TOTALS	122	44,652	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	21,214	7,030	3,319	31,563	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,214	7,030	3,319	31,563	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.69%

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 118 and days of care provided 2,336

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 University Nsg & Rehab Ctr # 0046557 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	209,892	17,641	11,275	238,808		238,808	(231)	238,577			1
2	Food Purchase		205,168		205,168		205,168	(972)	204,196			2
3	Housekeeping	103,286	25,636		128,922		128,922		128,922			3
4	Laundry	81,609	13,015	627	95,251		95,251		95,251			4
5	Heat and Other Utilities			172,485	172,485		172,485		172,485			5
6	Maintenance	65,333	26,791	55,006	147,130		147,130	998	148,128			6
7	Other (specify):*											7
8	TOTAL General Services	460,120	288,251	239,393	987,764		987,764	(205)	987,559			8
	B. Health Care and Programs											
9	Medical Director			36,500	36,500		36,500		36,500			9
10	Nursing and Medical Records	1,973,432	148,459	34,800	2,156,691		2,156,691	27,658	2,184,349			10
10a	Therapy		3,429	428,938	432,367		432,367	(88,447)	343,920			10a
11	Activities	60,594	7,487	5,597	73,678		73,678		73,678			11
12	Social Services	54,451	1,327	4,290	60,068		60,068		60,068			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,088,477	160,702	510,125	2,759,304		2,759,304	(60,789)	2,698,515			16
	C. General Administration											
17	Administrative	117,734			117,734		117,734		117,734			17
18	Directors Fees											18
19	Professional Services			216,883	216,883		216,883	9,942	226,825			19
20	Dues, Fees, Subscriptions & Promotions			5,919	5,919		5,919	997	6,916			20
21	Clerical & General Office Expenses	177,288	21,873	92,397	291,558		291,558	(71,441)	220,117			21
22	Employee Benefits & Payroll Taxes			551,630	551,630		551,630	39,576	591,206			22
23	Inservice Training & Education			3,125	3,125		3,125		3,125			23
24	Travel and Seminar			13,541	13,541		13,541	34,177	47,718			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,307	101,307		101,307	365	101,672			26
27	Other (specify):*											27
28	TOTAL General Administration	295,022	21,873	984,802	1,301,697		1,301,697	13,616	1,315,313			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,843,619	470,826	1,734,320	5,048,765		5,048,765	(47,378)	5,001,387			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 University Nsg & Rehab Ctr #0046557 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			53,695	53,695		53,695	3,295	56,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,357	1,357		1,357	22,720	24,077			32
33	Real Estate Taxes			74,865	74,865		74,865		74,865			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	173,921	413,921			34
35	Rent-Equipment & Vehicles			39,741	39,741		39,741		39,741			35
36	Other (specify):*											36
37	**TOTAL Ownership**			409,658	409,658		409,658	199,936	609,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,626	1,626		1,626		1,626			38
39	Ancillary Service Centers		168,288	11,899	180,187		180,187		180,187			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,594	256,594		256,594		256,594			42
43	Other (specify):* **Bad Debt**			81,460	81,460		81,460	(81,460)				43
44	**TOTAL Special Cost Centers**		168,288	351,579	519,867		519,867	(81,460)	438,407			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,843,619	639,114	2,495,557	5,978,290		5,978,290	71,098	6,049,388			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 University Nsg & Rehab Ctr # 0046557 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 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	(972)	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	727	30		9
10	Interest and Other Investment Income	(6)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(231)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,460)	43		24
25	Fund Raising, Advertising and Promotional	(20,127)	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	(79,621)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,690)		$	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)	252,788	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 252,788		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 71,098		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

University Nsg & Rehab Ctr

ID# 0046557

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (70,753)	21	1
2	Physician Fees	(565)	10	2
3	Marketing Supplies	(8,303)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(79,621)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(231)	0	0	0	0	0	0	0	0	0	0	(231)	1
2	Food Purchase	(972)	0	0	0	0	0	0	0	0	0	0	(972)	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	998	0	0	0	0	0	0	0	0	998	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,203)	0	998	0	0	0	0	0	0	0	0	(205)	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	(565)	0	28,223	0	0	0	0	0	0	0	0	27,658	10
10a	Therapy	0	(88,447)	0	0	0	0	0	0	0	0	0	(88,447)	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	(565)	(88,447)	28,223	0	0	0	0	0	0	0	0	(60,789)	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	9,942	0	0	0	0	0	0	0	0	9,942	19
20	Fees, Subscriptions & Promotions	0	0	997	0	0	0	0	0	0	0	0	997	20
21	Clerical & General Office Expenses	(99,183)	162	27,580	0	0	0	0	0	0	0	0	(71,441)	21
22	Employee Benefits & Payroll Taxes	0	0	39,576	0	0	0	0	0	0	0	0	39,576	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	34,177	0	0	0	0	0	0	0	0	34,177	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	365	0	0	0	0	0	0	0	0	365	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(99,183)	162	112,637	0	0	0	0	0	0	0	0	13,616	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(100,951)	(88,285)	141,858	0	0	0	0	0	0	0	0	(47,378)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number University Nsg & Rehab Ctr **#** 0046557 **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	727	0	2,568	0	0	0	0	0	0	0	0	3,295	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6)	19,795	2,931	0	0	0	0	0	0	0	0	22,720	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	173,921	0	0	0	0	0	0	0	0	0	173,921	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**	721	193,716	5,499	0	0	0	0	0	0	0	0	199,936	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(81,460)	0	0	0	0	0	0	0	0	0	0	(81,460)	43
44	**TOTAL Special Cost Centers**	(81,460)	0	0	0	0	0	0	0	0	0	0	(81,460)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(181,690)	105,431	147,357	0	0	0	0	0	0	0	0	71,098	45

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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	$ 160,684	Tru Rehab, LLC	100.00%	$ 127,501	$ (33,183)	1
2	V	10a	Occupational Therapy	162,795	Tru Rehab, LLC	100.00%	129,176	(33,619)	2
3	V	10a	Speech Therapy	68,814	Tru Rehab, LLC	100.00%	54,603	(14,211)	3
4	V	10a	Therapy Management Fee	36,000	Tru Rehab, LLC	100.00%	28,566	(7,434)	4
5	V								5
6	V	21	Clerical and General		Davis Ide HCP		162	162	6
7	V	32	Interest		Davis Ide HCP		19,795	19,795	7
8	V	34	Rent	240,000	Davis Ide HCP		413,921	173,921	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 668,293			$ 773,724	$ * 105,431	14

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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%	$ 998	$ 998	15
16	V	10	Nursing		Ide Management Group, LLC	100.00%	28,223	28,223	16
17	V	19	Professional Fees		Ide Management Group, LLC	100.00%	9,942	9,942	17
18	V	20	Dues, Fees, Subscriptions		Ide Management Group, LLC	100.00%	997	997	18
19	V	21	Clerical and General		Ide Management Group, LLC	100.00%	147,580	147,580	19
20	V	22	Employee Benefits		Ide Management Group, LLC	100.00%	39,576	39,576	20
21	V	24	Travel and Seminar		Ide Management Group, LLC	100.00%	34,177	34,177	21
22	V	26	Insurance		Ide Management Group, LLC	100.00%	365	365	22
23	V	30	Depreciation		Ide Management Group, LLC	100.00%	2,568	2,568	23
24	V	32	Interest		Ide Management Group, LLC	100.00%	2,931	2,931	24
25	V								25
26	V	21	Management Fees	120,000	Ide Management Group, LLC	100.00%		(120,000)	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			$ 120,000			$ 267,357	$ * 147,357	39

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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 University Nsg & Rehab Ctr # 0046557 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	2.42	6.05	Alloc Salary	$ 21,210	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	$ 21,210		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 University Nsg & Rehab Ctr # 0046557 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	$	31,563	$ 998	1
2	10	Nursing	Inpatient Days	520,848	21	465,727	465,727	31,563	28,223	2
3	19	Professional Fees	Inpatient Days	520,848	21	164,068		31,563	9,942	3
4	20	Dues, Fees, Subscriptions	Inpatient Days	520,848	21	16,459		31,563	997	4
5	21	Clerical and General	Inpatient Days	520,848	21	2,435,345	2,155,175	31,563	147,580	5
6	22	Employee Benefits	Inpatient Days	520,848	21	653,083		31,563	39,576	6
7	24	Travel and Seminar	Inpatient Days	520,848	21	563,986		31,563	34,177	7
8	26	Insurance	Inpatient Days	520,848	21	6,020		31,563	365	8
9	30	Depreciation	Inpatient Days	520,848	21	42,379		31,563	2,568	9
10	32	Interest	Inpatient Days	520,848	21	48,362		31,563	2,931	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		$ 267,357	25

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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 University Nsg & Rehab Ctr **#** 0046557 **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.**	$ 75,657	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.)		$ 76,970	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,313	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,552	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.		$ 74,865	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	73,416	8
	2012	73,878	9
	2013	74,952	10
	2014	74,858	11
	2015	76,970	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 University Nsg & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046557

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.	14-2-15-15-11-201-002.001	Nursing Home	$ 76,970.00	$ 76,970.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,970.00	$ 76,970.00

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 University Nsg & Rehab Ctr # 0046557 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,290 B. General Construction Type: Exterior Brick Frame _____ 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 University Nsg & Rehab Ctr # 0046557 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	Tile Flooring			2004	970	35	27.5	35		439	9
10	Storage Building			2004	1,441	52	27.5	52		653	10
11	Hand Rails			2004	4,933	179	27.5	179		2,220	11
12	Concrete Wall			2005	1,475	54	27.5	54		624	12
13	Nurses Station			2006	1,198	44	27.5	44		441	13
14	Exhaust Duct & Fan			2007	1,776	105	15	118	13	1,231	14
15	A/C Compressor			2007	600	22	27.5	22		371	15
16	Sewer Pipe			2007	4,500	200	20	225	25	2,366	16
17	Awning			2007	928	55	15	62	7	611	17
18	Fence & Line Posts			2007	836	38	20	42	4	432	18
19	Commercial Electric Heater			2007	2,625	164	10	263	99	2,488	19
20	Carpet			2008	1,000	100	10	100		892	20
21	Wall W/4X4 Posts			2008	1,398	93	15	93		823	21
22	Wiring In Kitchen			2008	918	61	15	61		540	22
23	Fire Alarm			2008	1,407	94	15	94		821	23
24	Sidewalks Metal Roof			2008	2,741	183	15	183		1,584	24
25	Tile & Carpet			2008	1,549	103	15	103		886	25
26	Seal Coat Asphalt			2008	2,518	168	15	168		1,413	26
27	Carpet			2008	674	45	15	45		363	27
28	Generator			2009	21,623	1,442	15	1,442		17,599	28
29	Sidewalk			2009	1,664	111	15	111		869	29
30	Fence			2009	919	61	15	61		465	30
31	Kitchen Wall			2010	6,915	251	27.5	251		1,666	31
32	Propane Tank			2010	1,888	69	27.5	69		449	32
33	Heater Thru the Wall			2010	276	39	7	39		250	33
34	Tile Flooring			2011	809	29	27.5	29		175	34
35	Storage Building			2011	1,202	44	27.5	44		261	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 University Nsg & Rehab Ctr # 0046557 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	Hand Rails	2011	$ 4,127	$ 150	27.5	$ 150	$	$ 894	37
38	Concrete Wall	2011	1,262	46	27.5	46		273	38
39	Nurses Station	2011	1,071	39	27.5	39		232	39
40	Exhaust Duct & Fan	2011	1,181	79	15	79		453	40
41	A/C Compressor	2011	353	13	27.5	13		76	41
42	Sewer Pipes	2011	3,461	183	20	173	(10)	1,205	42
43	Awning	2011	668	42	15	45	3	293	43
44	Fence & Line Posts	2011	656	35	20	33	(2)	228	44
45	Commercial Electric Heater	2011	1,310	97	10	131	34	924	45
46	Carpet	2011	288	21	10	29	8	203	46
47	Wall W/4X4 Posts	2011	538	34	15	36	2	236	47
48	Wiring In Kitchen	2011	353	22	15	24	2	155	48
49	Fire Alarm	2011	541	34	15	36	2	238	49
50	Sidewalks	2011	1,055	66	15	70	4	463	50
51	Tile & Carpet	2011	560	37	15	37		224	51
52	Seal Coat Asphalt	2011	965	64	15	64		386	52
53	Carpet	2011	259	16	15	17	1	114	53
54	Generator	2011	9,731	649	15	649		3,892	54
55	Sidewalk	2011	749	50	15	50		299	55
56	Fence	2011	414	28	15	28		165	56
57	Kitchen Wall	2011	6,804	247	27.5	247		1,474	57
58	Propane Tank	2011	1,861	68	27.5	68		403	58
59	Heater Thru Wall	2011	118	12	7	17	5	106	59
60	Shower Floor & Walls	2011	6,887	459	15	459		2,563	60
61	Tub/Shower	2011	860	59	15	57	(2)	326	61
62	Tile In Bathrooms	2011	6,887	459	15	459		2,526	62
63	Concrete Slab	2011	1,850	123	15	123		658	63
64	Improvements	2011	4,415	294	15	294		1,521	64
65	Flooring	2012	11,825	430	27.5	430		1,935	65
66	Adj Per Audit	2012	27,666	2,642	10	2,767	125	21,936	66
67	Water Heater 80 Gallon Electric	2013	6,050	504	12	504		1,807	67
68	Roof Replacement Wing A	2013	20,735	2,074	10	2,074		6,912	68
69									69
70	TOTAL (lines 4 thru 69)		$ 194,284	$ 12,917		$ 13,237	$ 320	$ 94,054	70

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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	
1	Totals from Page 12A, Carried Forward		$ 194,284	$ 12,917		$ 13,237	$ 320	$ 94,054	1
2									2
3	Water Heater 119 Gallon Electric	2014	7,820	782	10	782		1,694	3
4	Renovation 2015	2015	39,950	1,998	20	1,998		3,995	4
5	Lighting/Electrical	2015	1,525	76	20	76		133	5
6	Back Flow Preventer	2015	4,750	238	20	238		416	6
7	Front Building Sign	2015	3,731	187	20	187		295	7
8	Awning	2015	3,196	160	20	160		240	8
9	Asphault	2015	10,800	540	20	540		810	9
10	Roof Top Air Conditioner	2015	8,000	400	20	400		567	10
11	26 Windows	2015	16,911	846	20	846		1,198	11
12	Flooring Project Kitchen / Dining Room	2016	37,955	1,898	20	1,898		1,898	12
13	Tempering Valve Cartridge	2016	1,690	63	20	63		63	13
14	Circulating Pump and Piping	2016	1,488	19	20	19		19	14
15	Gas Line to Kitchen	2016	2,098	26	20	26		26	15
16	Flooring Kitchen	2016	1,536	6	20	6		6	16
17	Crash Rail	2016	911	4	20	4		4	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 336,642	$ 20,160		$ 20,480	$ 320	$ 105,418	34

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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	$ 232,343	$ 20,259	$ 23,234	$ 2,975	3-15	$ 155,290	71
72	Current Year Purchases	50,535	4,976	4,976		5-7	4,976	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 282,878	$ 25,235	$ 28,210	$ 2,975		$ 160,266	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	$ 41,500	$ 8,300	$ 8,300	$	5	$ 11,758	76
77										77
78										78
79										79
80	TOTALS			$ 41,500	$ 8,300	$ 8,300	$		$ 11,758	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)	$ 661,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,695	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,990	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,295	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 277,442	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 University Nsg & Rehab Ctr # 0046557 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:		122	11/1/03	$ 240,000	21	20	3
4	Additions							4
5								5
6								6
7	TOTAL		122		$ 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: $ 39,741 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 University Nsg & Rehab Ctr # 0046557 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 University Nsg & Rehab Ctr

STATE OF ILLINOIS
0046557 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	3,053	$ 162,795	$	3,053	$ 162,795	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,134	68,814		1,134	68,814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,549	160,684		3,549	160,684	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				168,288		168,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-3					5,634		5,634	12
13	Other (specify): Lab	39-3					6,265		6,265	13
14	TOTAL			$	7,736	$ 392,293	$ 180,187	7,736	$ 572,480	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 University Nsg & Rehab Ctr **#** 0046557 **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	$ 62,293	$	1
2	Cash-Patient Deposits	55,088		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,437,968		3
4	Supply Inventory (priced at)	9,098		4
5	Short-Term Investments			5
6	Prepaid Insurance	36,061		6
7	Other Prepaid Expenses	(6,875)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,593,633	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	48,588		14
15	Leasehold Improvements, at Historical Cost	288,054		15
16	Equipment, at Historical Cost	324,378		16
17	Accumulated Depreciation (book methods)	(277,442)		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)**	$ 383,578	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,977,211	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,905,258	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	28,000		29
30	Accrued Salaries Payable	252,226		30
31	Accrued Taxes Payable (excluding real estate taxes)	91,701		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,575		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Settlement Reserve	59,500		36
37	Resident Trust Fund Liability	55,088		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,466,348	$	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)**	$ 2,466,348	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (489,137)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,977,211	$	48

***(See instructions.)**

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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**	$ (126,454)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(293,933)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (420,387)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(68,750)	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)**	$ (68,750)	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)**	$ (489,137)	24 *

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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	$ 5,467,917	1
2	Discounts and Allowances for all Levels	(506,909)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,961,008	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	828,707	6
7	Oxygen	21,514	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 850,221	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	972	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,819	17
18	Sale of Supplies to Non-Patients	(174)	18
19	Laboratory	7,999	19
20	Radiology and X-Ray	3,756	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 98,372	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc. Revenue	(67)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (67)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,909,540	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	987,764	31
32	Health Care	2,759,304	32
33	General Administration	1,301,697	33
	B. Capital Expense		
34	Ownership	409,658	34
	C. Ancillary Expense		
35	Special Cost Centers	263,273	35
36	Provider Participation Fee	256,594	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,978,290	40
41	**Income before Income Taxes (line 30 minus line 40)****	(68,750)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (68,750)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,120,958	44
45	Private Pay - Net Inpatient Revenue	1,210,020	45
46	Medicare - Net Inpatient Revenue	519,534	46
47	Other-(specify) Net Inpatient Revenue	110,496	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,961,008	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 University Nsg & Rehab Ctr # 0046557 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	2,286	2,332	$ 88,626	$ 38.00	1
2	Assistant Director of Nursing	1,051	1,080	41,958	38.85	2
3	Registered Nurses	8,511	8,915	253,659	28.45	3
4	Licensed Practical Nurses	27,379	28,974	667,012	23.02	4
5	CNAs & Orderlies	68,252	71,894	897,332	12.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,001	5,421	60,594	11.18	9
10	Activity Assistants					10
11	Social Service Workers	3,378	3,717	54,451	14.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,355	18,752	209,892	11.19	15
16	Dishwashers					16
17	Maintenance Workers	3,727	4,117	65,333	15.87	17
18	Housekeepers	9,972	10,431	103,286	9.90	18
19	Laundry	7,454	8,049	81,609	10.14	19
20	Administrator	1,703	1,822	117,734	64.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,082	3,282	106,535	32.46	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	1,773	1,988	24,845	12.50	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	2,047	2,162	70,753	32.73	33
34	TOTAL (lines 1 - 33)	162,971	172,936	$ 2,843,619 *	$ 16.44	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	291	$ 10,193	1.3	35
36	Medical Director	Monthly	36,500	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)	291	$ 46,693		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 University Nsg & Rehab Ctr # 0046557 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Lietz	Administrator		$ 29,464
Brent Hoffman	Administrator		88,270
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 117,734

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
		$
BKD	Acct	7,411
Helper Broom, LLC	Legal	1,849
Drewry Simmons Vornehm	Legal	836
Sanberg Phoenix & Von Gontard	Legal	38
Husch Blackwell	Legal	500
Parrish / RCI	IT	9,162
Management Fees	Professional Fees	120,000
Integrated Resources Mgmt	Professional Fees	77,087
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 216,883

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,935
Unemployment Compensation Insurance	53,837
FICA Taxes	210,057
Employee Health Insurance	171,247
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	3,555
Physicals	1,425
Human Resources	2,572
Ide Mgmt Group	39,578
TOTAL (agree to Schedule V, line 22, col.8)	$ 591,206

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Madison County Health Dept	375
CLIA Lab Program	150
Rosenthal Liscense and Insurance	285
Ide Mgmt Group	998
Dues and Subscriptions	1,128
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,916

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	8,598
Hotel	4,055
Seminar Expense	
Ide Mgmt Group	34,178
Tuition and Education	887
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 47,718

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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. $ **15,873** 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. $ **256,594**
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