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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0046532

Facility Name: North Logan Healthcare Ctr

Address: 801 North Logan Ave (Number) Danville (City) 61832 (Zip Code)

County: Vermilion

Telephone Number: (217) 443-3106 **Fax #** (217) 443-3187

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: TYSEN ADAMS **Telephone Number:** (317) 383.4000
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 1/1/13 to 12/31/13 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 Sorrells
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) BKD, LLP - Consultant
(Firm Name & Address) BKD, LLP, 201 N ILLINOIS ST, ST 700, INDIANPOLIS, IN 46244
(Telephone) (317) 383.4000 Fax # (317) 383.4200

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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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	21,121	7,110	4,044	32,275	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,121	7,110	4,044	32,275	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.87%

D. How many bed-hold days during this year were paid by the Department?
NONE (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 1/1/2004

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 108 and days of care provided 4,044

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	205,976	12,083		218,059		218,059		218,059			1
2	Food Purchase		203,669		203,669		203,669	(126)	203,543			2
3	Housekeeping	85,041	22,852	350	108,243		108,243		108,243			3
4	Laundry	82,616	18,481		101,097		101,097		101,097			4
5	Heat and Other Utilities			135,270	135,270		135,270		135,270			5
6	Maintenance	61,191	26,447	62,519	150,157		150,157	921	151,078			6
7	Other (specify):*											7
8	TOTAL General Services	434,824	283,532	198,139	916,495		916,495	795	917,290			8
	B. Health Care and Programs											
9	Medical Director			17,100	17,100		17,100		17,100			9
10	Nursing and Medical Records	1,728,325	209,924	13,680	1,951,929		1,951,929		1,951,929			10
10a	Therapy		5,394	3,952	9,346		9,346		9,346			10a
11	Activities	92,212	3,668	3,245	99,125		99,125		99,125			11
12	Social Services	90,242		1,304	91,546		91,546	(41,595)	49,951			12
13	CNA Training											13
14	Program Transportation			5,590	5,590		5,590		5,590			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,910,779	218,986	44,871	2,174,636		2,174,636	(41,595)	2,133,041			16
	C. General Administration											
17	Administrative	80,007		272,000	352,007		352,007	(210,904)	141,103			17
18	Directors Fees											18
19	Professional Services			167,932	167,932		167,932	24,922	192,854			19
20	Dues, Fees, Subscriptions & Promotions			15,203	15,203		15,203	(6,893)	8,310			20
21	Clerical & General Office Expenses	87,273	15,828	(40,660)	62,441		62,441	152,286	214,727			21
22	Employee Benefits & Payroll Taxes			441,233	441,233		441,233		441,233			22
23	Inservice Training & Education											23
24	Travel and Seminar			528	528		528	24,583	25,111			24
25	Other Admin. Staff Transportation			4,385	4,385		4,385	(872)	3,513			25
26	Insurance-Prop.Liab.Malpractice			94,765	94,765		94,765	(6,672)	88,093			26
27	Other (specify):*							38,176	38,176			27
28	TOTAL General Administration	167,280	15,828	955,386	1,138,494		1,138,494	14,626	1,153,120			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,512,883	518,346	1,198,396	4,229,625		4,229,625	(26,174)	4,203,451			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 North Logan Healthcare Ctr #0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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			13,550	13,550		13,550	5,153	18,703			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							698	698			32
33	Real Estate Taxes			103,858	103,858		103,858		103,858			33
34	Rent-Facility & Grounds			336,000	336,000		336,000	1,585	337,585			34
35	Rent-Equipment & Vehicles			60,957	60,957		60,957	2,504	63,461			35
36	Other (specify):*											36
37	TOTAL Ownership			514,365	514,365		514,365	9,940	524,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,477	581,541	761,018		761,018	(20,996)	740,022			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			293,101	293,101		293,101		293,101			42
43	Other (specify):* X-RAY & LAB			30,696	30,696		30,696		30,696			43
44	TOTAL Special Cost Centers		179,477	905,338	1,084,815		1,084,815	(20,996)	1,063,819			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,512,883	697,823	2,618,099	5,828,805		5,828,805	(37,230)	5,791,575			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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,089)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,153	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(126)	02		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	(1,180)	21		18
19	Entertainment	(248)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,606)	20		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	20,539			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 9,443		$	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)	(46,673)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (46,673)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (37,230)		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

STATE OF ILLINOIS **Page 5A**

North Logan Healthcare Ctr

ID# 0046532

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (4,668)	21	1
2	MARKETING TRAVEL	(872)	25	2
3	MARKETING SALARY	(41,595)	12	3
4	ADJUST LEASE EXPENSE TO ACTUAL	(404)	34	4
5	OTHER DEPARTMENT EXPENSE	68,078	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	20,539		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Logan Healthcare Ctr **#** 0046532 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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	(126)	0	0	0	0	0	0	0	0	0	0	(126)	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	921	0	0	0	0	0	0	0	0	921	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(126)	0	921	0	0	0	0	0	0	0	0	795	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	(41,595)	0	0	0	0	0	0	0	0	0	0	(41,595)	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**	(41,595)	0	0	0	0	0	0	0	0	0	0	(41,595)	16
	C. General Administration													
17	Administrative	0	0	(210,904)	0	0	0	0	0	0	0	0	(210,904)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	24,922	0	0	0	0	0	0	0	0	24,922	19
20	Fees, Subscriptions & Promotions	(8,606)	0	1,713	0	0	0	0	0	0	0	0	(6,893)	20
21	Clerical & General Office Expenses	56,141	0	96,145	0	0	0	0	0	0	0	0	152,286	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	(248)	0	24,831	0	0	0	0	0	0	0	0	24,583	24
25	Other Admin. Staff Transportation	(872)	0	0	0	0	0	0	0	0	0	0	(872)	25
26	Insurance-Prop.Liab.Malpractice	0	0	(6,672)	0	0	0	0	0	0	0	0	(6,672)	26
27	Other (specify):*	0	0	38,176	0	0	0	0	0	0	0	0	38,176	27
28	**TOTAL General Administration**	46,415	0	(31,789)	0	0	0	0	0	0	0	0	14,626	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	4,694	0	(30,868)	0	0	0	0	0	0	0	0	(26,174)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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	5,153	0	0	0	0	0	0	0	0	0	0	5,153	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	698	0	0	0	0	0	0	0	0	698	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(404)	0	1,989	0	0	0	0	0	0	0	0	1,585	34
35	Rent-Equipment & Vehicles	0	0	2,504	0	0	0	0	0	0	0	0	2,504	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,749	0	5,191	0	0	0	0	0	0	0	0	9,940	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	(20,996)	0	0	0	0	0	0	0	0	0	(20,996)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(20,996)	0	0	0	0	0	0	0	0	0	(20,996)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,443	(20,996)	(25,677)	0	0	0	0	0	0	0	0	(37,230)	45

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 6-SUPPLEMENTAL		SEE 6-SUPPLEMENTAL		SEE 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	39	Physical Therapy	$ 239,651	Tru Rehab, LLC	100.00%	$ 230,919	$ (8,732)	1
2	V	39	Occupational Therapy	277,729	Tru Rehab, LLC	100.00%	267,610	(10,119)	2
3	V	39	Speech Therapy	22,861	Tru Rehab, LLC	100.00%	22,028	(833)	3
4	V	39	Therapy Management Fee	36,000	Tru Rehab, LLC	100.00%	34,688	(1,312)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 576,241			$ 555,245	$ * (20,996)	14

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	5	UTILITIES	$	IDE MANAGEMENT GROUP, LLC	100.00%	$	$	15
16	V	6	MAINTENANCE		IDE MANAGEMENT GROUP, LLC	100.00%	921	921	16
17	V	10	NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17	ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	61,096	61,096	18
19	V	19	PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	24,922	24,922	19
20	V	20	DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	1,713	1,713	20
21	V	21	CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	96,145	96,145	21
22	V	24	TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	24,831	24,831	22
23	V	25	TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26	INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%	(6,672)	(6,672)	24
25	V	27	EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	38,176	38,176	25
26	V	32	INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%	698	698	26
27	V	34	RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	1,989	1,989	27
28	V	35	RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	2,504	2,504	28
29	V								29
30	V	17	MANAGEMENT FEES	272,000	IDE MANAGEMENT GROUP, LLC	100.00%		(272,000)	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			$ 272,000			$ 246,323	$ * (25,677)	39

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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%	BLOOMINGTON NURSING AND REHAB	BLOOMINGTON, IN	IDE MANAGEMENT GROUP, LLC	GREENFIELD, IN	BOOKKEEPING/MGT	1
2			CLOVERLEAF OF KNIGHTSVILLE	KNIGHTSVILLE, IN	TRU REHAB, LLC	VINCENNES, IN	THERAPY-REHAB	2
3			COLONIAL HEALTH CARE	CROWN POINT, IN	DAVIS IHC PROP	GREENFIELD, IN	PROPERTY MGT	3
4			CORYDON NURSING AND REHAB	CORYDON, IN				4
5			ESSEX NURSING AND REHAB	LEBANON, IN				5
6			HIGHLAND NURSING AND REHAB	HIGHLAND, IN				6
7			KENDALLVILLE MANOR	KENDALVILLE, IN				7
8			LINTON NURSING AND REHAB	LINTON, IN				8
9			MADISON HEALTH CARE CENTER	INDIANAPOLIS, IN				9
10			MERIDIAN NURSING AND REHAB	INDIANAPOLIS, IN				10
11			NORTH RIDGE NURSING	ALBION, IN				11
12			NORTH RIDGE ASSISTED LIVING (ALF)	ALBION, IN				12
13			LANDMARK HEALTHCARE	NEW ALBANY, IN				13
14			ROCKVILLE NURSING AND REHAB	ROCKVILLE, IN				14
15			SUGAR CREEK REHAB	GREENFIELD, IN				15
16			THE CHATEAU AT SUGAR CREEK (ALF)	GREENFIELD, IN				16
17			TERRE HAUTE NURSING AND REHAB	TERRE HAUTE, IN				17
18			WARSAW MEADOWS	WARSAW, IN				18
19			WILLOW MANOR	VINCENNES, IN				19
20			WOODLAND MANOR	ELKHART, IN				20
21			GRINNELL HEALTH CARE CENTER	GRINNELL, IA				21
22			NEWTON HEALTH CARE CENTER	NEWTON, IA				22
23			URBANDALE HEALTH CARE CENTER	URBANDALE, IA				23
24			ZEARING HEALTH CARE CENTER	ZEARING, IA				24
25			APPLETON HEALTH CARE CENTER	APPLETON, WI				25
26			LAWRENCE MANOR HC CENTER	INDIANAPOLIS, IN				26
27			SUMMERFIELD HEALTH CARE	CLOVERDALE, IN				27
28			RURAL HEALTHCARE	INDIANAPOLIS, IN				28
29			UNIVERSITY NURSING & REHAB CENTER	EVANSVILLE, IN				29
30								30

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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%	EDWARDSVILLE NSG & REHAB CTR	EDWARDSVILLE, IL				1
2			UNIVERSITY NSG & REHAB CTR	EDWARDSVILLE, IL				2
3			PARIS HEALTHCARE CENTER	PARIS, IL				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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	2.1	5.25%	Alloc Salary	$ 18,363	17-7	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	$ 18,363		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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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: 5430 W. US 40
City / State / Zip Code: GREENFIELD, IN 46140
Phone Number: (317) 947-0233
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	5	UTILITIES	INPATIENT DAYS	615,180	31	$	$	32,275	$ 0	1
2	6	MAINTENANCE	INPATIENT DAYS	615,180	31	17,563		32,275	921	2
3	10	NURSING	INPATIENT DAYS	615,180	31			32,275	0	3
4	17	ADMINISTRATIVE	INPATIENT DAYS	615,180	31	1,164,534	1,164,534	32,275	61,096	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	615,180	31	475,028		32,275	24,922	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	615,180	31	32,648		32,275	1,713	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	615,180	31	1,832,573	1,515,206	32,275	96,145	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	615,180	31	473,284		32,275	24,831	8
9	25	TRANSPORTATION	INPATIENT DAYS	615,180	31			32,275	0	9
10	26	INSURANCE	INPATIENT DAYS	615,180	31	(127,174)		32,275	(6,672)	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	615,180	31	727,664		32,275	38,176	11
12	32	INTEREST	INPATIENT DAYS	615,180	31	13,296		32,275	698	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	615,180	31	37,921		32,275	1,989	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	615,180	31	47,734		32,275	2,504	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,695,071	$ 2,679,740		$ 246,323	25

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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: TRU REHAB, LLC
Street Address: 3801 OLD BRUCEVILLE ROAD
City / State / Zip Code: VINCENNES, IN 47591
Phone Number: (812) 886-4677
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	39	PHYSICAL THERAPY	DIRECT ALLOCATION			$	$		$ 230,919	1
2	39	OCCUPATIONAL THERAPY	DIRECT ALLOCATION						267,610	2
3	39	SPEECH THERAPY	DIRECT ALLOCATION						22,028	3
4	39	THERAPY MGT FEES	DIRECT ALLOCATION						34,688	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					$	$		$ 555,245	25

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												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 North Logan Healthcare Ctr # 0046532 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 104,856	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.)		$ 97,947	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,909)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 110,767	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.		$ 103,858	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	106,127	8
	2009	107,760	9
	2010	105,756	10
	2011	102,860	11
	2012	97,947	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Logan Healthcare Ctr COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0046532

CONTACT PERSON REGARDING THIS REPORT TYSEN ADAMS

TELEPHONE (317) 383.4000 FAX #: (317) 383.4200

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-06-411-006-0060	LONG TERM CARE PROPERTY	$ 96,188.62	$ 96,188.62
2.	23-06-411-011-0060	LONG TERM CARE PROPERTY	$ 879.20	$ 879.20
3.	23-06-411-012-0060	LONG TERM CARE PROPERTY	$ 879.20	$ 879.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,947.02	$ 97,947.02

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,933 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 3

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).

N/A

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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Various			2004	13,863		20	693	693	7,271	9
10	Various			2005	29,957		20	1,498	1,498	14,146	10
11	Various			2006	8,930		20	447	447	3,573	11
12	Various			2007	610		20	31	31	497	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

*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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Carpeting	2008	$ 530	$	20	$ 27	$ 27	$ 160	37
38	New Secure Care Key Pad	2008	1,657		20	83	83	497	38
39	Wallpapering	2008	1,036		20	52	52	311	39
40	Wallpapering	2008	1,455		20	73	73	437	40
41	Install Remote Generator Annuciator Panel	2008	3,641		20	182	182	1,092	41
42	P&G Pump Housing Repair and Upgrade	2008	3,145		20	157	157	942	42
43	Holby Mixing Valve - Boiler Repair	2009	3,114		20	156	156	779	43
44	Room Renovations - Paintwork	2009	3,698		20	185	185	925	44
45	Heater Booster	2010	2,915		20	146	146	583	45
46	Awning	2011	3,385		20	169	169	507	46
47	Fire Alarm System	2011	9,335		20	467	467	1,401	47
48	Fire Alarm Inspection	2011	3,041		20	152	152	456	48
49	Two Shunt Trip Breakers	2011	2,950		20	148	148	444	49
50	Generator Starter Replaced	2011	3,581		20	179	179	537	50
51	Main Sign Relocation	2013	4,970		10	166	166	166	51
52	Plumbing Installed Backflows on Pipes	2013	5,378		25	18	18	18	52
53	Renovation of 1st Floor	2013	67,452		15	375	375	375	53
54				4,653			(4,653)		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)		$ 174,643	$ 4,653		$ 5,404	$ 751	$ 35,117	70

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 118,030	$ 8,301	$ 11,803	$ 3,502	10	$ 63,407	71
72	Current Year Purchases	23,902	596	596		10	596	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 141,932	$ 8,897	$ 12,399	$ 3,502		$ 64,003	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		1999 FORD VAN	2010	$ 4,500	$	$ 900	$ 900	5	$ 3,600	76
77										77
78										78
79										79
80	TOTALS			$ 4,500	$	$ 900	$ 900		$ 3,600	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)	$ 321,075	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,550	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,703	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,153	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 102,720	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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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:		108		$ 335,596			3
4	Additions							4
5								5
6								6
7	TOTAL		108		$ 335,596 **			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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 60,957 Description: SEE ATTACHED SCHEDULE
    (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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	39-03	hrs	$	3,968	$ 277,729	$	3,968	$ 277,729	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		327	22,861		327	22,861	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		3,424	239,651		3,424	239,651	4
5	Physician Care	39-03	visits			661			661	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				179,477		179,477	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance / Therapy Fees /Other Ancillary					40,639			40,639	12
13	Other (specify): Lab & x-ray	43-03				30,696			30,696	13
14	TOTAL			$	7,719	$ 612,237	$ 179,477	7,719	$ 791,714	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 64,141	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	847,328		3
4	Supply Inventory (priced at)	10,695		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	38,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 960,164	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	135,744		15
16	Equipment, at Historical Cost	146,432		16
17	Accumulated Depreciation (book methods)	(120,509)		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): ASSET CLEARING	32,246		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 193,913	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,154,077	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 949,904	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,587		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,223		31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,767		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES	(108)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,188,373	$	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	RESIDENT TRUST LIABILITY	28,981		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 28,981	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,217,354	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (63,277)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,154,077	$	48

***(See instructions.)**

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 378,023	1
2	Restatements (describe):		2
3			3
4	**CHANGE IN MEMBERS EQUITY**	(15,438)	4
5	**PY AUDIT ADJUSTMENTS**	85,234	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 447,819	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(511,096)	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)**	$ (511,096)	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)**	$ (63,277)	24 *

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 5,355,783	1
2	Discounts and Allowances for all Levels	(1,368,734)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,987,049	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,052,948	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,052,948	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	170,157	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,597	19
20	Radiology and X-Ray	8,976	20
21	Other Medical Services	52,420	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 242,150	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35,562	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35,562	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,317,709	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	916,495	31
32	Health Care	2,174,636	32
33	General Administration	1,138,494	33
	B. Capital Expense		
34	Ownership	514,365	34
	C. Ancillary Expense		
35	Special Cost Centers	791,714	35
36	Provider Participation Fee	293,101	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,828,805	40
41	**Income before Income Taxes (line 30 minus line 40)****	(511,096)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (511,096)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,577,322	44
45	Private Pay - Net Inpatient Revenue	577,070	45
46	Medicare - Net Inpatient Revenue	926,968	46
47	Other-(specify) Part B, Bad Debts, Prior Year	(94,311)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,987,049	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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	731	749	$ 18,914	$ 25.25	1
2	Assistant Director of Nursing	2,080	2,080	58,099	27.93	2
3	Registered Nurses	13,772	14,395	359,168	24.95	3
4	Licensed Practical Nurses	19,559	21,112	423,748	20.07	4
5	CNAs & Orderlies	68,395	73,141	741,636	10.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,534	9,348	92,212	9.86	10
11	Social Service Workers	3,901	4,133	90,242	21.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,060	16,118	205,976	12.78	15
16	Dishwashers					16
17	Maintenance Workers	4,515	4,822	61,191	12.69	17
18	Housekeepers	8,086	8,848	85,041	9.61	18
19	Laundry	8,918	9,509	82,616	8.69	19
20	Administrator	2,080	2,080	80,007	38.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,639	3,969	87,273	21.99	23
24	Clerical					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	1,848	2,090	36,608	17.52	31
32	Other Health C: Clinical Manager	2,080	2,080	90,152	43.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,198	174,474	$ 2,512,883 *	$ 14.40	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		$		35
36	Medical Director	Monthly	17,100	9.3	36
37	Medical Records Consultant		1,325	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	Monthly	8,051	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	1,765	11.3	44
45	Social Service Consultant		1,304	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,545		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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joan Darr	ADMINISTRATOR		$ 80,007
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,007

B. Administrative - Other

Description	Amount
Management Fees - Ide Management Group	$ 272,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 272,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 167,932
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 167,932

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,371
Unemployment Compensation Insurance	
FICA Taxes	274,699
Employee Health Insurance	127,163
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 441,233

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	$
Advertising: Employee Recruitment	2,661
Health Care Worker Background Check	496
(Indicate # of checks performed)	
Patient Background Checks 158	2,816
Advertising & Promotion	8,606
Dues & Subscriptions	374
Licenses & Fees	250
Allocated from Ide Management	1,713
Less: Public Relations Expense	( )
Non-allowable advertising	(8,606)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,310

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	528
Allocated from Ide Management	24,831
Entertainment Expense	(248)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,111

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/13 Ending: 12/31/13

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? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,101** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **293,101**
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. $ ____ 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? **YES**
If YES, attach a complete explanation. See Attached Schedule
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% L14**
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. $ ____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: ____

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.