

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: <u>0046540</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Edwardsville Nsg & Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.																																																	
Address: <u>401 St Mary Dr</u> <u>Edwardsville</u> <u>62025</u> Number City Zip Code																																																			
County: <u>Madison</u>																																																			
Telephone Number: <u>(618) 692-1330</u> Fax # <u>(815) 338-9478</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>1/1/04</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Mike Sorrells</u> (Title) <u>Chief Financial Officer</u>																																																	
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____		Paid Preparer (Signed) _____ (Date) _____ (Print Name) <u>BKD, LLP - Consultant</u> (Firm Name & Address) <u>BKD, LLP</u> <u>201 N ILLINOIS ST, ST 700, INDIANAPOLIS, IN 46244</u> (Telephone) <u>(317) 317.383.4000</u> Fax # <u>(317) 383.4200</u>	
☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																														
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		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact: Name: <u>TYSEN ADAMS</u> Telephone Number: <u>(317) 383.4000</u> Email Address: _____																																																			
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

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

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>23,954</u>	<u>4,061</u>	<u>5,284</u>	<u>33,299</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,954</u>	<u>4,061</u>	<u>5,284</u>	<u>33,299</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.82%

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?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

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 ☒Date 1/1/2004NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 32 and days of care provided 2,942Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	182,363	9,003	7,917	199,283		199,283		199,283		1
2	Food Purchase		196,935		196,935		196,935	(119)	196,816		2
3	Housekeeping	103,574	28,475		132,049		132,049		132,049		3
4	Laundry	74,904	9,941		84,845		84,845		84,845		4
5	Heat and Other Utilities			114,200	114,200		114,200		114,200		5
6	Maintenance	57,596	15,143	45,017	117,756		117,756	34	117,790		6
7	Other (specify):*										7
8	TOTAL General Services	418,437	259,497	167,134	845,068		845,068	(85)	844,983		8
	B. Health Care and Programs										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	1,763,115	144,954	11,041	1,919,110		1,919,110		1,919,110		10
10a	Therapy		5,333	759	6,092		6,092		6,092		10a
11	Activities	56,315	4,844	5,811	66,970		66,970		66,970		11
12	Social Services	94,975	1,172	41	96,188		96,188	(48,284)	47,904		12
13	CNA Training										13
14	Program Transportation			5,131	5,131		5,131		5,131		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,914,405	156,303	64,783	2,135,491		2,135,491	(48,284)	2,087,207		16
	C. General Administration										
17	Administrative	74,031		29,000	103,031		103,031	37,797	140,828		17
18	Directors Fees										18
19	Professional Services			277,773	277,773		277,773	(52,590)	225,183		19
20	Dues, Fees, Subscriptions & Promotions			19,614	19,614		19,614	(10,186)	9,428		20
21	Clerical & General Office Expenses	93,801	14,334	28,171	136,306		136,306	67,795	204,101		21
22	Employee Benefits & Payroll Taxes			418,649	418,649		418,649		418,649		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,391	2,391		2,391	22,004	24,395		24
25	Other Admin. Staff Transportation			12,104	12,104		12,104	(1,530)	10,574		25
26	Insurance-Prop.Liab.Malpractice			74,190	74,190		74,190		74,190		26
27	Other (specify):*							29,193	29,193		27
28	TOTAL General Administration	167,832	14,334	861,892	1,044,058		1,044,058	92,483	1,136,541		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,500,674	430,134	1,093,809	4,024,617		4,024,617	44,114	4,068,731		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			10,158	10,158		10,158	3,634	13,792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,847	72,847		72,847	(185)	72,662			32
33	Real Estate Taxes			75,786	75,786		75,786		75,786			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	47,971	227,971			34
35	Rent-Equipment & Vehicles			28,547	28,547		28,547	1,361	29,908			35
36	Other (specify):*											36
37	TOTAL Ownership			367,338	367,338		367,338	52,781	420,119			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,494	438,701	596,195		596,195	(8,638)	587,557			39
40	Barber and Beauty Shops			541	541		541		541			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,309	253,309		253,309		253,309			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,494	692,551	850,045		850,045	(8,638)	841,407			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,500,674	587,628	2,153,698	5,242,000		5,242,000	88,257	5,330,257			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(2,728)	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	3,634	30		9
10	Interest and Other Investment Income	(185)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	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				18
19	Entertainment	(496)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	1,052	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,983)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(124,562)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,387)		\$	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)	222,644		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 222,644		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 88,257		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

ID# 0046540
Report Period Beginning: 1/1/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	BANK CHARGES	\$ (2,292)	21	1
2	VENDING MACHINE	(1,424)	21	2
3	MISC INCOME	(5,581)	21	3
4	LEGAL SETTLEMENT	(110,000)	19	4
5	LATE CHARGES & FEES	(750)	21	5
6	MARKETING SALARY	(48,284)	12	6
7	MARKETING TRAVEL	(1,530)	25	7
8	ADJUST LEASE EXPENSE TO ACTUAL	45,299	34	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
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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	(124,562)		49

STATE OF ILLINOIS

Summary A

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

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(119)	0	0	0	0	0	0	0	0	0	0	(119)	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	34	0	0	0	0	0	0	0	0	34	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(119)	0	34	0	0	0	0	0	0	0	0	(85)	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	(48,284)	0	0	0	0	0	0	0	0	0	0	(48,284)	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	(48,284)	0	0	0	0	0	0	0	0	0	0	(48,284)	16
	C. General Administration													
17	Administrative	0	0	37,797	0	0	0	0	0	0	0	0	37,797	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(108,948)	0	56,358	0	0	0	0	0	0	0	0	(52,590)	19
20	Fees, Subscriptions & Promotions	(10,983)	0	797	0	0	0	0	0	0	0	0	(10,186)	20
21	Clerical & General Office Expenses	(12,775)	0	80,570	0	0	0	0	0	0	0	0	67,795	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	(496)	0	22,500	0	0	0	0	0	0	0	0	22,004	24
25	Other Admin. Staff Transportation	(1,530)	0	0	0	0	0	0	0	0	0	0	(1,530)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	29,193	0	0	0	0	0	0	0	0	29,193	27
28	TOTAL General Administration	(134,732)	0	227,215	0	0	0	0	0	0	0	0	92,483	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(183,135)	0	227,249	0	0	0	0	0	0	0	0	44,114	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	3,634	0	0	0	0	0	0	0	0	0	0	3,634	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(185)	0	0	0	0	0	0	0	0	0	0	(185)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	45,299	0	2,672	0	0	0	0	0	0	0	0	47,971	34
35	Rent-Equipment & Vehicles	0	0	1,361	0	0	0	0	0	0	0	0	1,361	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	48,748	0	4,033	0	0	0	0	0	0	0	0	52,781	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	(8,638)	0	0	0	0	0	0	0	0	0	(8,638)	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	(8,638)	0	0	0	0	0	0	0	0	0	(8,638)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(134,387)	(8,638)	231,282	0	0	0	0	0	0	0	0	88,257	45

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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	39	Physical Therapy	\$ 185,466	Tru Rehab, LLC	100.00%	\$ 181,757	\$ (3,709)	1
2	V	39	Occupational Therapy	195,918	Tru Rehab, LLC	100.00%	192,000	(3,918)	2
3	V	39	Speech Therapy	32,567	Tru Rehab, LLC	100.00%	31,916	(651)	3
4	V	39	Therapy Management Fee	18,000	Tru Rehab, LLC	100.00%	17,640	(360)	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			\$ 431,951			\$ 423,313	\$ * (8,638)	14

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

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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	IDE MANAGEMENT GROUP, LLC	100.00%	\$		15
16	V	6	MAINTENANCE		IDE MANAGEMENT GROUP, LLC	100.00%	34	34	16
17	V	10	NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17	ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	66,797	66,797	18
19	V	19	PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	56,358	56,358	19
20	V	20	DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	797	797	20
21	V	21	CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	80,570	80,570	21
22	V	24	TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	22,500	22,500	22
23	V	25	TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26	INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%			24
25	V	27	EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	29,193	29,193	25
26	V	32	INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%			26
27	V	34	RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	2,672	2,672	27
28	V	35	RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	1,361	1,361	28
29	V								29
30	V	17	MANAGEMENT FEES	29,000	IDE MANAGEMENT GROUP, LLC	100.00%		(29,000)	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			\$ 29,000			\$ 260,282	\$ * 231,282	39

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

Facility Name & ID Number

Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARK IDE	SHAREHOLDER	Administrative	100.00	SEE ATTACHED	3	7.50	Alloc Salary	\$ 6,230	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	\$ 6,230		13

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INPATIENT DAYS	525,604	28	\$	\$	33,299	\$ 0	1
2	6	MAINTENANCE	INPATIENT DAYS	525,604	28	540		33,299	34	2
3	10	NURSING	INPATIENT DAYS	525,604	28			33,299	0	3
4	17	ADMINISTRATIVE	INPATIENT DAYS	525,604	28	1,054,346	1,054,346	33,299	66,797	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	525,604	28	889,583		33,299	56,358	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	525,604	28	12,587		33,299	797	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	525,604	28	1,271,766	783,963	33,299	80,571	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	525,604	28	355,145		33,299	22,500	8
9	25	TRANSPORTATION	INPATIENT DAYS	525,604	28			33,299	0	9
10	26	INSURANCE	INPATIENT DAYS	525,604	28			33,299	0	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	525,604	28	460,777		33,299	29,192	11
12	32	INTEREST	INPATIENT DAYS	525,604	28			33,299	0	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	525,604	28	42,181		33,299	2,672	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	525,604	28	21,487		33,299	1,361	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,108,412	\$ 1,838,309		\$ 260,282	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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			\$	\$		\$ 181,757	1
2	39	OCCUPATIONAL THERAPY	DIRECT ALLOCATION						192,000	2
3	39	SPEECH THERAPY	DIRECT ALLOCATION						31,916	3
4	39	THERAPY MGT FEES	DIRECT ALLOCATION						17,640	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					\$	\$		\$ 423,313	25

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	IDE MANAGEMENT GROUP	X		LOAN PAYABLE				699,222			32,290	6
7	OMNICARE		X	NOTE PAYABLE				0			5,842	7
8	DIHCP	X		LOAN PAYABLE				365,691			34,715	8
9	TOTAL Facility Related						\$	1,064,913			\$ 72,847	9
	B. Non-Facility Related*											
10	INTEREST INCOME		X								(185)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (185)	14
15	TOTALS (line 9+line14)						\$	1,064,913			\$ 72,662	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.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1.	Real Estate Tax accrual used on 2011 report.	\$	75,786	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.)	\$	76,061	2		
3.	Under or (over) accrual (line 2 minus line 1).	\$	275	3		
4.	Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	75,511	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.	\$	75,786	7		
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	76,707	8			
	2008	79,684	9			
	2009	74,401	10			
	2010	75,786	11			
	2011	76,061	12			

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Edwardsville Nsg & Rehab Ctr

COUNTY

Madison

FACILITY IDPH LICENSE NUMBER

0046540

CONTACT PERSON REGARDING THIS REPORT

TYSEN ADAMS

TELEPHONE

(317) 383.4000

FAX #:

(417) 383.4200

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	10-1-16-07-00-000-019.003	LONG TERM CARE PROPERTY	\$ 76,060.76	\$ 76,060.76
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 76,060.76	\$ 76,060.76

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 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. ☒ (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? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2004		5,848		20	292	292	2,631
10	Various		2005		9,368		20	468	468	4,470
11	Various		2006		25,252		20	1,263	1,263	9,642
12	Various		2007		10,551		20	528	528	3,166
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

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	New Roof	2008	\$ 4,200	\$	20	\$ 210	\$ 210	\$ 1,050	37
38	Rebuild shower stalls	2008	3,000		20	150	150	750	38
39	Rebuild shower stalls	2008	3,382		20	169	169	845	39
40	Hot Water Heater	2009	5,918		20	296	296	1,184	40
41	Cabinets & Counter Tops	2009	2,670		20	134	134	535	41
42	Hot Water Heater	2009	6,418		20	321	321	1,284	42
43	Lumber, Cabinets, Countertops, Window Treatments, Paint	2010	7,220		20	361	361	1,083	43
44	Concrete Work	2011	7,357		20	368	368	736	44
45	Concrete Work	2011	4,388		20	219	219	438	45
46				4,908			(4,908)		46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 95,572	\$ 4,908		\$ 4,779	\$ (129)	\$ 27,814	70

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

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	\$ 82,126	\$ 5,250	\$ 8,213	\$ 2,963		\$ 60,339	71
72	Current Year Purchases	62,422		800	800		800	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 144,548	\$ 5,250	\$ 9,013	\$ 3,763		\$ 61,139	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 240,120	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,158	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,792	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,634	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 88,953	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.
- ☒ 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:				\$ 225,299			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 225,299			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:
-
- *

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: \$ 28,547
- Description: Dish machine 1,071; Medical equip 27,476
- (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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$	4,068	\$ 195,918	\$	4,068	\$ 195,918	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		638	32,567		638	32,567	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		3,432	185,466		3,432	185,466	4
5	Physician Care		visits			193			193	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				145,121		145,121	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-ray						12,373		12,373	12
13	Other (specify): Ambulance, therapy fees					24,557			24,557	13
14	TOTAL			\$	8,138	\$ 438,701	\$ 157,494	8,138	\$ 596,195	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 74,803	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	782,099		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,653		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 872,555	\$	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	62,875		15
16	Equipment, at Historical Cost	144,548		16
17	Accumulated Depreciation (book methods)	(117,771)		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)	\$ 89,652	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 962,207	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 363,103	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	70,000		29
30	Accrued Salaries Payable	91,595		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,879		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,227		32
33	Accrued Interest Payable	80,366		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(648)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 717,522	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,064,913		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)	\$ 1,064,913	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,782,435	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (820,228)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 962,207	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (181,075)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4	AUDIT ADJUSTMENTS (GOODWILL, BAD DEBTS)	(806,141)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (987,215)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	58,711	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) Member's Contribution	108,276	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 166,987	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)	\$ (820,228)	24 *

* This must agree with page 17, line 47.

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.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,262,801	1
2	Discounts and Allowances for all Levels	(951,188)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,311,613	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	792,895	6
7	Oxygen	7,601	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 800,496	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	312	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,146	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,356	19
20	Radiology and X-Ray	199	20
21	Other Medical Services	78,399	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 181,412	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	185	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 185	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and vending income	7,005	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,005	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,300,711	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	845,068	31
32	Health Care	2,135,491	32
33	General Administration	1,044,058	33
	B. Capital Expense		
34	Ownership	367,338	34
	C. Ancillary Expense		
35	Special Cost Centers	596,736	35
36	Provider Participation Fee	253,309	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,242,000	40
41	Income before Income Taxes (line 30 minus line 40)**	58,711	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 58,711	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,032,520	44
45	Private Pay - Net Inpatient Revenue	494,169	45
46	Medicare - Net Inpatient Revenue	675,212	46
47	Other-(specify)		47
48	Other-(specify) <u>Part B, Bad Debts, Prior Year Income</u>	109,712	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,311,613	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,728	2,058	\$ 54,345	\$ 26.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,374	11,081	226,565	20.45	3
4	Licensed Practical Nurses	23,655	25,715	506,647	19.70	4
5	CNAs & Orderlies	62,445	67,568	975,558	14.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,047	4,302	56,315	13.09	10
11	Social Service Workers	5,249	5,723	94,975	16.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,567	19,166	182,363	9.51	15
16	Dishwashers					16
17	Maintenance Workers	3,496	3,886	57,596	14.82	17
18	Housekeepers	11,795	13,160	103,574	7.87	18
19	Laundry	5,554	6,045	74,904	12.39	19
20	Administrator	2,053	2,363	74,031	31.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,441	5,128	93,801	18.29	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,404	166,195	\$ 2,500,674 *	\$ 15.05	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 7,917	1.3	35
36	Medical Director	Monthly	42,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	94	5,191	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	94	\$ 55,108		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Brian Koontz		ADMINISTRATOR		\$ 74,031	Workers' Compensation Insurance		\$ 22,504	IDPH License Fee		\$	
					Unemployment Compensation Insurance			Advertising: Employee Recruitment		(65)	
					FICA Taxes		269,086	Health Care Worker Background Check		2,057	
					Employee Health Insurance		119,376	(Indicate # of checks performed 16)			
					Employee Meals			Patient Background Checks		104	
					Illinois Municipal Retirement Fund (IMRF)*			ADVERTISING & PROMOTION		10,983	
					Other Employee Benefits		7,683	DUES & SUBSCRIPTIONS		2,014	
								LICENSES & FEES		4,625	
								ALLOCATION FROM IDE MGT		797	
								Less: Public Relations Expense		()	
								Non-allowable advertising		(10,983)	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 74,031				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,428	
B. Administrative - Other					TOTAL (agree to Schedule V, line 22, col.8)		\$ 418,649	G. Schedule of Travel and Seminar**			
Description				Amount	Description	Line #	Amount	Description		Amount	
Management Fees - Ide Management Group				\$ 29,000			\$	Out-of-State Travel		\$	
								In-State Travel			
								Seminar Expense		2,391	
								ALLOCATION FROM IDE MGT		22,500	
								Entertainment Expense		(496)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 29,000				(agree to Sch. V, line 24, col. 8)			
C. Professional Services					TOTAL		\$	TOTAL		\$ 24,395	
Vendor/Payee		Type		Amount							
SEE ATTACHED SCHEDULE				\$ 277,773							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 277,773							

*** Attach copy of IMRF notifications**

****See instructions.**

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

\$ 20,303

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.

\$ 253,309

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.

\$ N/A

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% on 14

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name: N/A

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

YES

(19) 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?

YES

Attach invoices and a summary of services for all architect and appraisal fees.