FOR BHF USE

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

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: 0046540

Facility Name: Edwardsville Nsg & Rehab Ctr

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

County: Madison

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: 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. Illonois St, Suite 700, Indianapolis, 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 Edwardsville Nsg & Rehab Ctr # 0046540 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	22,698	8,416	2,740	33,854	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,698	8,416	2,740	33,854	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.29%

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 01/01/2004

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,740

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 Edwardsville Nsg & Rehab Ctr # 0046540 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	180,415	12,097	9,040	201,552		201,552	(653)	200,899			1
2	Food Purchase		206,514		206,514		206,514	(259)	206,255			2
3	Housekeeping	122,266	31,142		153,408		153,408		153,408			3
4	Laundry	67,734	6,992		74,726		74,726		74,726			4
5	Heat and Other Utilities			120,391	120,391		120,391		120,391			5
6	Maintenance	57,384	19,916	32,475	109,775		109,775	967	110,742			6
7	Other (specify):*											7
8	**TOTAL General Services**	427,799	276,661	161,906	866,366		866,366	55	866,421			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	1,838,358	122,570	15,129	1,976,057		1,976,057		1,976,057			10
10a	Therapy		5,367	778	6,145		6,145		6,145			10a
11	Activities	64,358	5,778	7,882	78,018		78,018		78,018			11
12	Social Services	97,296	292		97,588		97,588	(42,145)	55,443			12
13	CNA Training											13
14	Program Transportation			1,774	1,774		1,774		1,774			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,000,012	134,007	67,563	2,201,582		2,201,582	(42,145)	2,159,437			16
	C. General Administration											
17	Administrative	70,878		180,000	250,878		250,878	(115,915)	134,963			17
18	Directors Fees											18
19	Professional Services			147,127	147,127		147,127	26,141	173,268			19
20	Dues, Fees, Subscriptions & Promotions			30,012	30,012		30,012	(21,750)	8,262			20
21	Clerical & General Office Expenses	105,630	18,614	69,914	194,158		194,158	65,654	259,812			21
22	Employee Benefits & Payroll Taxes			417,750	417,750		417,750		417,750			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,325	4,325		4,325	24,638	28,963			24
25	Other Admin. Staff Transportation			13,549	13,549		13,549	(2,946)	10,603			25
26	Insurance-Prop.Liab.Malpractice			88,396	88,396		88,396	(6,999)	81,397			26
27	Other (specify):*							40,044	40,044			27
28	**TOTAL General Administration**	176,508	18,614	951,073	1,146,195		1,146,195	8,867	1,155,062			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,604,319	429,282	1,180,542	4,214,143		4,214,143	(33,223)	4,180,920			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr #0046540 **Report Period Beginning:** 1/1/13 **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			12,403	12,403		12,403	8,049	20,452			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,660	50,660		50,660	(1,240)	49,420			32
33	Real Estate Taxes			75,786	75,786		75,786		75,786			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(58,216)	253,784			34
35	Rent-Equipment & Vehicles			58,201	58,201		58,201	2,627	60,828			35
36	Other (specify):*											36
37	**TOTAL Ownership**			509,050	509,050		509,050	(48,780)	460,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		194,620	437,115	631,735		631,735	(15,505)	616,230			39
40	Barber and Beauty Shops			594	594		594	(320)	274			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			300,276	300,276		300,276		300,276			42
43	Other (specify):* **X-ray & Lab Expense**			28,054	28,054		28,054		28,054			43
44	**TOTAL Special Cost Centers**		194,620	766,039	960,659		960,659	(15,825)	944,834			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,604,319	623,902	2,455,631	5,683,852		5,683,852	(97,828)	5,586,024			45

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,049	30		9
10	Interest and Other Investment Income	(1,972)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(259)	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	(1,407)	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	(23,547)	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	(141,561)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,697)		$	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)	62,869		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 62,869		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,828)		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

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Edwardsville Nsg & Rehab Ctr

ID# **0046540**

Report Period Beginning: **1/1/13**

Ending: **12/31/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (2,283)	21	1
2	VENDING MACHINE	(1,457)	21	2
3	MISCELLANEOOUS INCOME	(714)	21	3
4	MARKETING SALARY	(42,145)	12	4
5	MARKETING TRAVEL	(2,946)	25	5
6	ADJUST LEASE EXPENSE TO ACTUAL	(60,303)	34	6
7	DIETARY REBATE/REFUND INCOME	(653)	01	7
8	BARBER/BEAUTY INCOME	(320)	40	8
9	OTHER DEPARTMENT EXPENSE	(30,740)	21	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**	(141,561)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr **#** 0046540 **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	(653)	0	0	0	0	0	0	0	0	0	0	(653)	1
2	Food Purchase	(259)	0	0	0	0	0	0	0	0	0	0	(259)	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	967	0	0	0	0	0	0	0	0	967	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(912)	0	967	0	0	0	0	0	0	0	0	55	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	(42,145)	0	0	0	0	0	0	0	0	0	0	(42,145)	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**	(42,145)	0	0	0	0	0	0	0	0	0	0	(42,145)	16
	C. General Administration													
17	Administrative	0	0	(115,915)	0	0	0	0	0	0	0	0	(115,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	26,141	0	0	0	0	0	0	0	0	26,141	19
20	Fees, Subscriptions & Promotions	(23,547)	0	1,797	0	0	0	0	0	0	0	0	(21,750)	20
21	Clerical & General Office Expenses	(35,194)	0	100,848	0	0	0	0	0	0	0	0	65,654	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	(1,407)	0	26,045	0	0	0	0	0	0	0	0	24,638	24
25	Other Admin. Staff Transportation	(2,946)	0	0	0	0	0	0	0	0	0	0	(2,946)	25
26	Insurance-Prop.Liab.Malpractice	0	0	(6,999)	0	0	0	0	0	0	0	0	(6,999)	26
27	Other (specify):*	0	0	40,044	0	0	0	0	0	0	0	0	40,044	27
28	**TOTAL General Administration**	(63,094)	0	71,961	0	0	0	0	0	0	0	0	8,867	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(106,151)	0	72,928	0	0	0	0	0	0	0	0	(33,223)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr **#** 0046540 **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	8,049	0	0	0	0	0	0	0	0	0	0	8,049	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,972)	0	732	0	0	0	0	0	0	0	0	(1,240)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(60,303)	0	2,087	0	0	0	0	0	0	0	0	(58,216)	34
35	Rent-Equipment & Vehicles	0	0	2,627	0	0	0	0	0	0	0	0	2,627	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(54,226)	0	5,446	0	0	0	0	0	0	0	0	(48,780)	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	(15,505)	0	0	0	0	0	0	0	0	0	(15,505)	39
40	Barber and Beauty Shops	(320)	0	0	0	0	0	0	0	0	0	0	(320)	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**	(320)	(15,505)	0	0	0	0	0	0	0	0	0	(15,825)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(160,697)	(15,505)	78,374	0	0	0	0	0	0	0	0	(97,828)	45

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 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	$ 188,287	Tru Rehab, LLC	100.00%	$ 181,424	$ (6,863)	1
2	V	39	Occupational Therapy	187,538	Tru Rehab, LLC	100.00%	180,705	(6,833)	2
3	V	39	Speech Therapy	31,634	Tru Rehab, LLC	100.00%	30,481	(1,153)	3
4	V	39	Therapy Management Fee	18,000	Tru Rehab, LLC	100.00%	17,344	(656)	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			$ 425,459			$ 409,954	$ * (15,505)	14

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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%	967	967	16
17	V	10	NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17	ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	64,085	64,085	18
19	V	19	PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	26,141	26,141	19
20	V	20	DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	1,797	1,797	20
21	V	21	CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	100,848	100,848	21
22	V	24	TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	26,045	26,045	22
23	V	25	TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26	INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%	(6,999)	(6,999)	24
25	V	27	EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	40,044	40,044	25
26	V	32	INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%	732	732	26
27	V	34	RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	2,087	2,087	27
28	V	35	RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	2,627	2,627	28
29	V								29
30	V	17	MANAGEMENT FEES	180,000	IDE MANAGEMENT GROUP, LLC	100.00%		(180,000)	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			$ 180,000			$ 258,374	$ * 78,374	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: 1/1/13 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 Edwardsville Nsg & Rehab Ctr # 0046540 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%	UNIVERSITY NSG & REHAB CTR	EDWARDSVILLE, IL				1
2			PARIS HEALTHCARE CENTER	PARIS, IL				2
3			NORTH LOGAN HEALTH CARE	DANVILLE, 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 Edwardsville Nsg & Rehab Ctr # 0046540 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	2.2	5.50%	Alloc Salary	$ 19,262	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	$ 19,262		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: 1/1/13 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	$	$	33,854	$	1
2	6	MAINTENANCE	INPATIENT DAYS	615,180	31	17,563		33,854	967	2
3	10	NURSING	INPATIENT DAYS	615,180	31			33,854		3
4	17	ADMINISTRATIVE	INPATIENT DAYS	615,180	31	1,164,534	1,164,534	33,854	64,085	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	615,180	31	475,028		33,854	26,141	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	615,180	31	32,648		33,854	1,797	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	615,180	31	1,832,573	1,515,206	33,854	100,848	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	615,180	31	473,284		33,854	26,045	8
9	25	TRANSPORTATION	INPATIENT DAYS	615,180	31			33,854		9
10	26	INSURANCE	INPATIENT DAYS	615,180	31	(127,174)		33,854	(6,999)	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	615,180	31	727,664		33,854	40,044	11
12	32	INTEREST	INPATIENT DAYS	615,180	31	13,296		33,854	732	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	615,180	31	37,921		33,854	2,087	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	615,180	31	47,734		33,854	2,627	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		$ 258,374	25

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 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			$	$		$ 181,424	1
2	39	OCCUPATIONAL THERAPY	DIRECT ALLOCATION						180,705	2
3	39	SPEECH THERAPY	DIRECT ALLOCATION						30,481	3
4	39	THERAPY MGT FEES	DIRECT ALLOCATION						17,344	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					$	$		$ 409,954	25

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 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**		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			29,443	6
7	DIHCP	X		LOAN PAYABLE				365,691			21,217	7
8												8
9	TOTAL Facility Related						$	$ 1,064,913			$ 50,660	9
	B. Non-Facility Related*											
10	INTEREST INCOME		X								(1,972)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,972)	14
15	TOTALS (line 9+line14)						$	$ 1,064,913			$ 48,688	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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.**	$ 75,511	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.)		$ 77,580	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,069	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,717	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:			
	2008	79,684	8
	2009	74,401	9
	2010	75,786	10
	2011	76,061	11
	2012	77,580	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 Edwardsville Nsg & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046540

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.	10-1-16-07-00-000-019.003	LONG TERM CARE PROPERTY	$ 77,579.80	$ 77,579.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,579.80	$ 77,579.80

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 Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 Ending: 12/31/13

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. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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	5,848		20	292	292	2,923	9
10	Various			2005	9,368		20	468	468	4,938	10
11	Various			2006	25,252		20	1,263	1,263	10,905	11
12	Various			2007	10,551		20	528	528	3,694	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 Edwardsville Nsg & Rehab Ctr # 0046540 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	New Roof	2008	$ 4,200	$	20	$ 210	$ 210	$ 1,260	37
38	Rebuild Shower Stalls	2008	3,000		20	150	150	900	38
39	Rebuild Shower Stalls	2008	3,382		20	169	169	1,014	39
40	Hot Water Heater	2009	5,918		20	296	296	1,480	40
41	Cabinets & Countertops	2009	2,670		20	134	134	669	41
42	Hot Water Heater	2009	6,418		20	321	321	1,605	42
43	Lumber, Cabinets, Countertops, Window Treatments	2010	7,220		20	361	361	1,444	43
44	Concrete Work	2011	7,357		20	368	368	1,104	44
45	Concrete Work	2011	4,388		20	219	219	657	45
46	Roof Replacement	2013	22,325		10	744	744	744	46
47	Trash Enclosure	2013	3,604		15	20	20	20	47
48	Water Heater	2013	4,800		10	40	40	40	48
49	Shower Renovation C Hall	2013	9,000		20	38	38	38	49
50				4,786			(4,786)		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)		$ 135,301	$ 4,786		$ 5,621	$ 835	$ 33,435	70

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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	$ 144,548	$ 7,617	$ 14,455	$ 6,838		$ 75,594	71
72	Current Year Purchases	7,520		376	376		376	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 152,068	$ 7,617	$ 14,831	$ 7,214		$ 75,970	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 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)	$ 287,369	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,403	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,452	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,049	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 109,405	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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:				$ 251,697			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 251,697 **			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 [X] NO
16. Rental Amount for movable equipment: $ 58,201 Description: See Attachment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/13 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 Edwardsville Nsg & Rehab Ctr # 0046540 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	$	3,865	$ 187,538	$	3,865	$ 187,538	1
2	Licensed Speech and Language Development Therapist	39.03	hrs		588	31,634		588	31,634	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39.03	hrs		3,648	188,287		3,648	188,287	4
5	Physician Care	39.03	visits			907			907	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.02	# of prescrpts				194,620		194,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance, Therapy Fees					28,749			28,749	12
13	Other (specify): Lab & X-Ray	43-3				28,054			28,054	13
14	TOTAL			$	8,101	$ 465,169	$ 194,620	8,101	$ 659,789	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 Edwardsville Nsg & Rehab Ctr # 0046540 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	$ 87,722	$	1
2	Cash-Patient Deposits	39,573		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	962,777		3
4	Supply Inventory (priced at)	10,689		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Asset Clearing	1,690		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,104,451	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	39,729		14
15	Leasehold Improvements, at Historical Cost	62,875		15
16	Equipment, at Historical Cost	152,068		16
17	Accumulated Depreciation (book methods)	(132,586)		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)**	$ 122,086	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,226,537	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,426,610	$	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	98,600		30
31	Accrued Taxes Payable (excluding real estate taxes)	42,886		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,433		32
33	Accrued Interest Payable	51,392		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	474,677		36
37	Resident Trust Fund Liability	39,573		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,277,171	$	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)**	$ 3,342,084	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,115,547)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,226,537	$	48

***(See instructions.)**

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 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**	$ (820,228)	1	
2	Restatements (describe):		2	
3	CHANGE IN MEMBERS EQUITY	7,351	3	
4	CHANGE IN ACCUMULATED SURPLUS	(418,105)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,230,982)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(884,566)	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) ROUNDING	1	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (884,565)	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)**	$ (2,115,547)	24	*

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 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	$ 5,845,122	1
2	Discounts and Allowances for all Levels	(2,026,976)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,818,146	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	794,197	6
7	Oxygen	30,574	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 824,771	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	320	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	130,330	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,846	19
20	Radiology and X-Ray	177	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,673	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,972	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,972	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and Vending Income	15,724	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,724	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,799,286	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	866,366	31
32	Health Care	2,201,582	32
33	General Administration	1,146,195	33
	B. Capital Expense		
34	Ownership	509,050	34
	C. Ancillary Expense		
35	Special Cost Centers	660,383	35
36	Provider Participation Fee	300,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,683,852	40
41	**Income before Income Taxes (line 30 minus line 40)****	(884,566)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (884,566)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,932,094	44
45	Private Pay - Net Inpatient Revenue	677,477	45
46	Medicare - Net Inpatient Revenue	636,239	46
47	Other-(specify)		47
48	Other-(specify) Part B Bad Debt, Prior Year Income	(427,664)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,818,146	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	2,080	$ 65,696	$ 31.58	1
2	Assistant Director of Nursing	1,399	1,559	36,987	23.72	2
3	Registered Nurses	10,204	11,130	280,211	25.18	3
4	Licensed Practical Nurses	24,941	27,068	593,284	21.92	4
5	CNAs & Orderlies	62,363	67,408	836,077	12.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,289	5,740	64,358	11.21	10
11	Social Service Workers	5,555	6,263	97,296	15.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,987	17,175	180,415	10.50	15
16	Dishwashers					16
17	Maintenance Workers	3,538	3,974	57,384	14.44	17
18	Housekeepers	11,773	13,064	122,266	9.36	18
19	Laundry	6,421	7,051	67,734	9.61	19
20	Administrator	1,984	2,200	70,878	32.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,095	4,559	105,630	23.17	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	1,852	2,096	26,103	12.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,241	171,367	$ 2,604,319 *	$ 15.20	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	Monthly	$ 9,040	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	110	6,059	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	110	$ 57,099		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Koontz	Administrator		$ 70,878
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,878

B. Administrative - Other

Description	Amount
Management Fees - Ide Management Group	$ 180,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 180,000

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule		$ 147,127
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 147,127

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,092
Unemployment Compensation Insurance	
FICA Taxes	271,369
Employee Health Insurance	122,744
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	(16,455)
TOTAL (agree to Schedule V, line 22, col.8)	$ 417,750

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 70
Advertising: Employee Recruitment	130
Health Care Worker Background Check	2,871
(Indicate # of checks performed 98)	
Patient Background Checks 74	1,269
Advertising & Promotions	23,547
Dues & Subscriptions	2,022
License & Fees	103
Allocation from Ide Mgmt	1,797
Less: Public Relations Expense	( )
Non-allowable advertising	(23,547)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,262

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,325
Allocation from Ide Mgmt	26,045
Entertainment Expense	(1,407)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,963

**See instructions.

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 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 Edwardsville Nsg & Rehab Ctr # 0046540 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. $ 19,695 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. $ 300,276
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.
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. $ 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.