FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0046532

Facility Name: North Logan Healthcare Ctr

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

County: Vermilion

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: TYSEN ADAMS **Telephone Number:** (317) 383.4000
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Mike Sorrells
(Title) Chief Financial Officer

Paid Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,792	4,457	4,295	30,544	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,792	4,457	4,295	30,544	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.48%

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 108 and days of care provided 4,295

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	221,446	13,056		234,502		234,502		234,502			1
2	Food Purchase		193,031		193,031		193,031	(139)	192,892			2
3	Housekeeping	77,944	20,036		97,980		97,980		97,980			3
4	Laundry	67,637	19,482		87,119		87,119		87,119			4
5	Heat and Other Utilities			123,396	123,396		123,396		123,396			5
6	Maintenance	53,158	19,613	59,737	132,508		132,508	131	132,639			6
7	Other (specify):*											7
8	TOTAL General Services	420,185	265,218	183,133	868,536		868,536	(8)	868,528			8
	B. Health Care and Programs											
9	Medical Director			20,800	20,800		20,800		20,800			9
10	Nursing and Medical Records	1,608,991	188,294	9,767	1,807,052		1,807,052		1,807,052			10
10a	Therapy		5,754	5,862	11,616		11,616		11,616			10a
11	Activities	84,976	2,864	2,830	90,670		90,670		90,670			11
12	Social Services	55,786			55,786		55,786	(32,994)	22,792			12
13	CNA Training											13
14	Program Transportation			3,300	3,300		3,300		3,300			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,749,753	196,912	42,559	1,989,224		1,989,224	(32,994)	1,956,230			16
	C. General Administration											
17	Administrative	84,772		120,000	204,772		204,772	(55,980)	148,792			17
18	Directors Fees											18
19	Professional Services			136,577	136,577		136,577	26,523	163,100			19
20	Dues, Fees, Subscriptions & Promotions			17,599	17,599		17,599	(8,912)	8,687			20
21	Clerical & General Office Expenses	82,347	24,358	51,701	158,406		158,406	141,107	299,513			21
22	Employee Benefits & Payroll Taxes			425,944	425,944		425,944		425,944			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,650	3,650		3,650	27,022	30,672			24
25	Other Admin. Staff Transportation			5,762	5,762		5,762	(204)	5,558			25
26	Insurance-Prop.Liab.Malpractice			76,066	76,066		76,066	3,330	79,396			26
27	Other (specify):*							45,818	45,818			27
28	TOTAL General Administration	167,119	24,358	837,299	1,028,776		1,028,776	178,704	1,207,480			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,337,057	486,488	1,062,991	3,886,536		3,886,536	145,702	4,032,238			29

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

Facility Name & ID Number North Logan Healthcare Ctr #0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			22,698	22,698		22,698	7,327	30,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							6,321	6,321			32
33	Real Estate Taxes			66,438	66,438		66,438		66,438			33
34	Rent-Facility & Grounds			336,000	336,000		336,000	(16,416)	319,584			34
35	Rent-Equipment & Vehicles			51,693	51,693		51,693	2,086	53,779			35
36	Other (specify):*											36
37	TOTAL Ownership			476,829	476,829		476,829	(682)	476,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		193,188	604,714	797,902		797,902	(18,511)	779,391			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			241,379	241,379		241,379		241,379			42
43	Other (specify):* X-RAY & LAB			31,786	31,786		31,786		31,786			43
44	TOTAL Special Cost Centers		193,188	877,879	1,071,067		1,071,067	(18,511)	1,052,556			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,337,057	679,676	2,417,699	5,434,432		5,434,432	126,509	5,560,941			45

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	(5,710)	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	7,327	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(139)	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	(375)	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	(10,606)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(83,614)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,117)		$	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)	219,626		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 219,626		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 126,509		37

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

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

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

STATE OF ILLINOIS **Page 5A**

North Logan Healthcare Ctr

ID# 0046532

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (4,373)	21	1
2	MARKETING TRAVEL	(204)	25	2
3	MARKETING SALARY	(32,994)	12	3
4	ADJUST LEASE EXPENSE TO ACTUAL	(18,101)	34	4
5	OTHER DEPARTMENT EXPENSE	(23,981)	21	5
6	MISCELLANEOUS INCOME	(49)	21	6
7	TAXES - NON-PROPERTY	(1,500)	21	7
8	CABLE TV EXPENSE	(50)	19	8
9	MARKETING EXPENSE	(995)	19	9
10	NON-ALLOWABLE LEGAL FEES	(1,367)	19	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**	(83,614)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Logan Healthcare Ctr **#** 0046532 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(139)	0	0	0	0	0	0	0	0	0	0	(139)	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	131	0	0	0	0	0	0	0	0	131	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(139)	0	131	0	0	0	0	0	0	0	0	(8)	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	(32,994)	0	0	0	0	0	0	0	0	0	0	(32,994)	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**	(32,994)	0	0	0	0	0	0	0	0	0	0	(32,994)	16
	C. General Administration													
17	Administrative	0	0	(55,980)	0	0	0	0	0	0	0	0	(55,980)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,412)	0	28,935	0	0	0	0	0	0	0	0	26,523	19
20	Fees, Subscriptions & Promotions	(10,606)	0	1,694	0	0	0	0	0	0	0	0	(8,912)	20
21	Clerical & General Office Expenses	(35,613)	0	176,720	0	0	0	0	0	0	0	0	141,107	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	(375)	0	27,397	0	0	0	0	0	0	0	0	27,022	24
25	Other Admin. Staff Transportation	(204)	0	0	0	0	0	0	0	0	0	0	(204)	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,330	0	0	0	0	0	0	0	0	3,330	26
27	Other (specify):*	0	0	45,818	0	0	0	0	0	0	0	0	45,818	27
28	**TOTAL General Administration**	(49,210)	0	227,914	0	0	0	0	0	0	0	0	178,704	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(82,343)	0	228,045	0	0	0	0	0	0	0	0	145,702	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	7,327	0	0	0	0	0	0	0	0	0	0	7,327	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	6,321	0	0	0	0	0	0	0	0	6,321	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(18,101)	0	1,685	0	0	0	0	0	0	0	0	(16,416)	34
35	Rent-Equipment & Vehicles	0	0	2,086	0	0	0	0	0	0	0	0	2,086	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,774)	0	10,092	0	0	0	0	0	0	0	0	(682)	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	(18,511)	0	0	0	0	0	0	0	0	0	(18,511)	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	(18,511)	0	0	0	0	0	0	0	0	0	(18,511)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,117)	(18,511)	238,137	0	0	0	0	0	0	0	0	126,509	45

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 254,797	Tru Rehab, LLC	100.00%	$ 246,909	$ (7,888)	1
2	V	39	Occupational Therapy	289,806	Tru Rehab, LLC	100.00%	280,835	(8,971)	2
3	V	39	Speech Therapy	10,972	Tru Rehab, LLC	100.00%	10,632	(340)	3
4	V	39	Therapy Management Fee	36,000	Tru Rehab, LLC	100.00%	34,688	(1,312)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 591,575			$ 573,064	$ * (18,511)	14

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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%	131	131	16
17	V	10	NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17	ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	64,020	64,020	18
19	V	19	PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	28,935	28,935	19
20	V	20	DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	1,694	1,694	20
21	V	21	CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	176,720	176,720	21
22	V	24	TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	27,397	27,397	22
23	V	25	TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26	INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%	3,330	3,330	24
25	V	27	EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	45,818	45,818	25
26	V	32	INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%	6,321	6,321	26
27	V	34	RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	1,685	1,685	27
28	V	35	RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	2,086	2,086	28
29	V								29
30	V	17	MANAGEMENT FEES	120,000	IDE MANAGEMENT GROUP, LLC	100.00%		(120,000)	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			$ 120,000			$ 358,137	$ * 238,137	39

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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%	KEOTA HEALTH CARE CENTER	KEOTA, IA				1
2			SIGOURNEY HEALTH CARE	SIGOURNEY, IA				2
3			UNIVERSITY NURSING & REHAB CENTER	EVANSVILLE, IN				3
4			EDWARDSVILLE NSG & REHAB CTR	EDWARDSVILLE, IL				4
5			UNIVERSITY NSG & REHAB CTR	EDWARDSVILLE, IL				5
6			PARIS HEALTHCARE CENTER	PARIS, IL				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	2.23	5.58%	Alloc Salary	$ 19,536	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	$ 19,536		13

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	554,738	35	$	$	30,544	$	1
2	6	MAINTENANCE	INPATIENT DAYS	554,738	35	2,382		30,544	131	2
3	10	NURSING	INPATIENT DAYS	554,738	35			30,544		3
4	17	ADMINISTRATIVE	INPATIENT DAYS	554,738	35	1,162,714	1,162,714	30,544	64,020	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	554,738	35	525,518		30,544	28,935	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	554,738	35	30,772		30,544	1,694	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	554,738	35	3,209,600	2,416,426	30,544	176,720	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	554,738	35	497,592		30,544	27,397	8
9	25	TRANSPORTATION	INPATIENT DAYS	554,738	35			30,544		9
10	26	INSURANCE	INPATIENT DAYS	554,738	35	60,487		30,544	3,330	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	554,738	35	832,136		30,544	45,818	11
12	32	INTEREST	INPATIENT DAYS	554,738	35	114,803		30,544	6,321	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	554,738	35	30,606		30,544	1,685	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	554,738	35	37,880		30,544	2,086	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,504,490	$ 3,579,140		$ 358,137	25

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			$	$		$ 246,909	1
2	39	OCCUPATIONAL THERAPY	DIRECT ALLOCATION						280,835	2
3	39	SPEECH THERAPY	DIRECT ALLOCATION						10,632	3
4	39	THERAPY MGT FEES	DIRECT ALLOCATION						34,688	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 573,064	25

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 110,767	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.)		$ 88,603	2
3. Under or (over) accrual (line 2 minus line 1).		$ (22,164)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 88,602	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.		$ 66,438	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	107,760	8
	2010	105,756	9
	2011	102,860	10
	2012	97,947	11
	2013	88,603	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Logan Healthcare Ctr COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0046532

CONTACT PERSON REGARDING THIS REPORT TYSEN ADAMS

TELEPHONE (317) 383.4000 FAX #: (317) 383-4200

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-06-411-006-0060	LONG TERM CARE PROPERTY	$ 86,902.80	$ 86,902.80
2.	23-06-411-011-0060	LONG TERM CARE PROPERTY	$ 850.02	$ 850.02
3.	23-06-411-012-0060	LONG TERM CARE PROPERTY	$ 850.02	$ 850.02
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,602.84	$ 88,602.84

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2004	13,863		20	693	693	7,964	9
10	Various			2005	29,957		20	1,498	1,498	15,644	10
11	Various			2006	8,930		20	447	447	4,020	11
12	Various			2007	610		20	31	31	528	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2008	$ 530	$	20	$ 27	$ 27	$ 187	37
38	New Secure Care Key Pad	2008	1,657		20	83	83	580	38
39	Wallpapering	2008	1,036		20	52	52	363	39
40	Wallpapering	2008	1,455		20	73	73	510	40
41	Install Remote Generator Annuciator Panel	2008	3,641		20	182	182	1,274	41
42	P&G Pump Housing Repair and Upgrade	2008	3,145		20	157	157	1,099	42
43	Holby Mixing Valve - Boiler Repair	2009	3,114		20	156	156	935	43
44	Room Renovations - Paintwork	2009	3,698		20	185	185	1,110	44
45	Heater Booster	2010	2,915		20	146	146	729	45
46	Awning	2011	3,385		20	169	169	676	46
47	Fire Alarm System	2011	9,335		20	467	467	1,868	47
48	Fire Alarm Inspection	2011	3,041		20	152	152	608	48
49	Two Shunt Trip Breakers	2011	2,950		20	148	148	592	49
50	Generator Starter Replaced	2011	3,581		20	179	179	716	50
51	Main Sign Relocation	2013	4,970		10	497	497	663	51
52	Plumbing Installed Backflows on Pipes	2013	5,378		25	215	215	233	52
53	1st Floor Dining Room, Conference Room,	2013	67,452		15	4,497	4,497	4,872	53
54	and Hallway Renovation Consisting of Wall Repair, Wall								54
55	and Ceiling Paint, Carpet and Vinyl Plank Flooring								55
56	Installation, and Door and Base Trim and 1st Floor Visitor								56
57	Bathroom Renovation Consisting of Grab Bars, Mirror,								57
58	Outlets, and Switch Replacement								58
59	Landscaping	2014	21,850		10	1,639	1,639	1,639	59
60	Booster Heater C15 208V, 3PH (HATCO)	2014	2,235		10	168	168	168	60
61	New carpet	2014	4,450		5	668	668	668	61
62	Water Heater and tempering valve replaced	2014	11,230		10	842	842	842	62
63	Circulator pumps for boiler	2014	3,950		10	66	66	66	63
64	Install door restrictions on elevator	2014	5,460		15	61	61	61	64
65	New contactor for air conditioner	2014	4,236		10	71	71	71	65
66	New condenser for air conditioner	2014	4,677		15	52	52	52	66
67	Duct work	2014	1,172		20	10	10	10	67
68	Air conditioner work	2014	5,924		7	141	141	141	68
69	Installed two new valves on boiler and water heater	2014	3,474		10	58	58	58	69
70	TOTAL (lines 4 thru 69)		$ 243,301	$		$ 13,830	$ 13,830	$ 48,947	70

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 243,301	$		$ 13,830	$ 13,830	$ 48,947	1
2	Curtain rods and drapes	2014	10,216		10	170	170	170	2
3	Premium Faux wood blinds	2014	8,842		10	147	147	147	3
4	Curtain rods and drapes	2014	2,009		10	33	33	33	4
5	New signs throughout building (stairwell,restroom,	2014	5,919		15	66	66	66	5
6	common room, etc.)								6
7				12,904			(12,904)		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 270,287	$ 12,904		$ 14,246	$ 1,342	$ 49,363	34

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 141,932	$ 9,108	$ 14,193	$ 5,085	10	$ 72,515	71
72	Current Year Purchases	13,949	686	686		10	686	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 155,881	$ 9,794	$ 14,879	$ 5,085		$ 73,201	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 FORD VAN	2010	$ 4,500	$	$ 900	$ 900	5	$ 4,500	76
77										77
78										78
79										79
80	TOTALS			$ 4,500	$	$ 900	$ 900		$ 4,500	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)	$ 430,668	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,698	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,025	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,327	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 127,064	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMEGA HEALTHCARE INVESTORS
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		108		$ 317,899			3
4	Additions							4
5								5
6								6
7	TOTAL		108		$ 317,899 **			7

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 51,693 Description: SEE ATTACHED SCHEDULE
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$	4,141	$ 289,806	$	4,141	$ 289,806	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		157	10,972		157	10,972	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		3,640	254,797		3,640	254,797	4
5	Physician Care		visits			175			175	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				193,188		193,188	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance / Therapy Fees /Other Ancillary					48,964			48,964	12
13	Other (specify): Lab & x-ray	43-03				31,786			31,786	13
14	TOTAL			$	7,938	$ 636,500	$ 193,188	7,938	$ 829,688	14

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

STATE OF ILLINOIS

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 172,068	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	930,414		3
4	Supply Inventory (priced at)	10,695		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,051		6
7	Other Prepaid Expenses	(483)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,133,745	$	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	231,388		15
16	Equipment, at Historical Cost	160,381		16
17	Accumulated Depreciation (book methods)	(143,207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ASSET CLEARING / CIP	655,402		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 903,964	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,037,709	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,130,796	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,603		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES	480		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,219,879	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	RESIDENT TRUST LIABILITY	28,981		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 28,981	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,248,860	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (211,151)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,037,709	$	48

*(See instructions.)

Facility Name & ID Number North Logan Healthcare Ctr **#** 0046532 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (63,277)	1
2	Restatements (describe):		2
3	CHANGE IN MEMBERS EQUITY	120,489	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 57,212	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(268,373)	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	10	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (268,363)	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)**	$ (211,151)	24 *

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 5,205,929	1
2	Discounts and Allowances for all Levels	(1,293,750)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,912,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,049,344	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,049,344	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	158,644	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,471	19
20	Radiology and X-Ray	7,548	20
21	Other Medical Services	32,450	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 201,113	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,374	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,374	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	49	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,166,059	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	868,536	31
32	Health Care	1,989,224	32
33	General Administration	1,028,776	33
	B. Capital Expense		
34	Ownership	476,829	34
	C. Ancillary Expense		
35	Special Cost Centers	829,688	35
36	Provider Participation Fee	241,379	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,434,432	40
41	**Income before Income Taxes (line 30 minus line 40)****	(268,373)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (268,373)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,543,825	44
45	Private Pay - Net Inpatient Revenue	746,423	45
46	Medicare - Net Inpatient Revenue	840,400	46
47	Other-(specify) Part B, Bad Debts, Prior Year	(218,469)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,912,179	49

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

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	1,965	2,078	$ 76,037	$ 36.59	1
2	Assistant Director of Nursing	1,968	2,080	58,498	28.12	2
3	Registered Nurses	17,053	18,234	437,027	23.97	3
4	Licensed Practical Nurses	14,616	15,877	309,237	19.48	4
5	CNAs & Orderlies	63,967	68,493	689,644	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,982	6,584	84,976	12.91	10
11	Social Service Workers	3,778	4,327	55,786	12.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,516	15,640	221,446	14.16	15
16	Dishwashers					16
17	Maintenance Workers	3,731	3,942	53,158	13.49	17
18	Housekeepers	9,059	9,626	77,944	8.10	18
19	Laundry	6,383	6,785	67,637	9.97	19
20	Administrator	1,851	1,947	84,772	43.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,881	2,065	82,347	39.88	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,902	2,124	38,548	18.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,652	159,802	$ 2,337,057 *	$ 14.62	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	20,800	9.3	36
37	Medical Records Consultant		993	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,320	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	1,109	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,222		49

C. CONTRACT NURSES

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joan Darr	ADMINISTRATOR		$ 24,870
Debra Gill	ADMINISTRATOR		59,902
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,772

B. Administrative - Other

Description	Amount
Management Fees - Ide Management Group	$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 120,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 136,577
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 136,577

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,955
Unemployment Compensation Insurance	
FICA Taxes	243,933
Employee Health Insurance	116,901
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	(4,845)
TOTAL (agree to Schedule V, line 22, col.8)	$ 425,944

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	$
Advertising: Employee Recruitment	3,059
Health Care Worker Background Check	288
(Indicate # of checks performed 18)	
Patient Background Checks 118	1,896
Advertising & Promotion	10,606
Dues & Subscriptions	802
Licenses & Fees	948
Allocated from Ide Management	1,694
Less: Public Relations Expense	( )
Non-allowable advertising	(10,606)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,687

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,650
Allocated from Ide Management	27,397
Entertainment Expense	(375)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30,672

**See instructions.

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. $ **45,485** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **241,379**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.