FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 01/01/04

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: Paul Traczek **Telephone Number:** 715-858-6619
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 01/01/17 to 12/31/17 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) Paul Traczek, Partner
(Firm Name & Address) Wipfli LLP, 3703 Oakwood Hills Parkway, Eau Claire, WI 54702
(Telephone) 715-858-6619 Fax # 715-832-2345

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: 01/01/17 Ending: 12/31/17

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 _____

	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	16,463	8,010	6,951	31,424	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,463	8,010	6,951	31,424	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.72%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/04

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/04 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 3,668

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	193,086	11,328	21,876	226,290		226,290		226,290			1
2	Food Purchase		213,889		213,889		213,889	(104)	213,785			2
3	Housekeeping	118,082	35,956	131	154,169		154,169		154,169			3
4	Laundry	62,477	9,135	1,007	72,619		72,619		72,619			4
5	Heat and Other Utilities			151,746	151,746		151,746		151,746			5
6	Maintenance	82,391	11,230	42,010	135,631		135,631	2,768	138,399			6
7	Other (specify):*											7
8	TOTAL General Services	456,036	281,538	216,770	954,344		954,344	2,664	957,008			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,015,542	221,652	62,646	2,299,840		2,299,840	30,000	2,329,840			10
10a	Therapy		3,789	631,270	635,059		635,059	(135,849)	499,210			10a
11	Activities	58,663	3,585	663	62,911		62,911		62,911			11
12	Social Services	47,007		255	47,262		47,262		47,262			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,121,212	229,026	718,834	3,069,072		3,069,072	(105,849)	2,963,223			16
	C. General Administration											
17	Administrative	81,050			81,050		81,050		81,050			17
18	Directors Fees											18
19	Professional Services			232,087	232,087		232,087	5,783	237,870			19
20	Dues, Fees, Subscriptions & Promotions			33,874	33,874		33,874		33,874			20
21	Clerical & General Office Expenses	177,291	33,075	95,975	306,341		306,341	(78,888)	227,453			21
22	Employee Benefits & Payroll Taxes			500,681	500,681		500,681	34,345	535,026			22
23	Inservice Training & Education			425	425		425		425			23
24	Travel and Seminar			26,933	26,933		26,933	15,577	42,510			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			97,821	97,821		97,821	(617)	97,204			26
27	Other (specify):* Bad Debt			2,435	2,435		2,435	(2,435)				27
28	TOTAL General Administration	258,341	33,075	990,231	1,281,647		1,281,647	(26,235)	1,255,412			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,835,589	543,639	1,925,835	5,305,063		5,305,063	(129,420)	5,175,643			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: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			146,425	146,425		146,425	3,148	149,573			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							37,642	37,642			32
33	Real Estate Taxes			118,076	118,076		118,076		118,076			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	107,376	347,376			34
35	Rent-Equipment & Vehicles			34,007	34,007		34,007		34,007			35
36	Other (specify):*											36
37	**TOTAL Ownership**			538,508	538,508		538,508	148,166	686,674			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,621	14,713	163,334		163,334		163,334			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,576	169,576		169,576		169,576			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		148,621	184,289	332,910		332,910		332,910			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,835,589	692,260	2,648,632	6,176,481		6,176,481	18,746	6,195,227			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: 01/01/17 Ending: 12/31/17

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	(104)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	731	30		9
10	Interest and Other Investment Income	(4,777)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,435)	27		24
25	Fund Raising, Advertising and Promotional	(21,608)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(94,432)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,625)		$	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)	141,371	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 141,371		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 18,746		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

North Logan Healthcare Ctr

ID# 0046532

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Income	$ (3,217)	21	1
2	Marketing Supplies	(21,759)	21	2
3	Bank Charges	(1,713)	21	3
4	Finance Charge and Late Fees	(5)	21	4
5	Marketing Travel	(3,584)	24	5
6	Marketing Wages	(58,154)	21	6
7	Fines & Penalties	(6,000)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(94,432)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Logan Healthcare Ctr **#** 0046532 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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	2,768	0	0	0	0	0	0	0	0	2,768	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(104)	0	2,768	0	0	0	0	0	0	0	0	2,664	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	30,000	0	0	0	0	0	0	0	0	30,000	10
10a	Therapy	0	(135,849)	0	0	0	0	0	0	0	0	0	(135,849)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(135,849)	30,000	0	0	0	0	0	0	0	0	(105,849)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,783	0	0	0	0	0	0	0	0	5,783	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(112,456)	1,725	31,843	0	0	0	0	0	0	0	0	(78,888)	21
22	Employee Benefits & Payroll Taxes	0	0	34,345	0	0	0	0	0	0	0	0	34,345	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,584)	0	19,161	0	0	0	0	0	0	0	0	15,577	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	(617)	0	0	0	0	0	0	0	0	(617)	26
27	Other (specify):*	(2,435)	0	0	0	0	0	0	0	0	0	0	(2,435)	27
28	**TOTAL General Administration**	(118,475)	1,725	90,515	0	0	0	0	0	0	0	0	(26,235)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(118,579)	(134,124)	123,283	0	0	0	0	0	0	0	0	(129,420)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	731	0	2,417	0	0	0	0	0	0	0	0	3,148	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,777)	36,421	5,998	0	0	0	0	0	0	0	0	37,642	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	107,376	0	0	0	0	0	0	0	0	0	107,376	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,046)	143,797	8,415	0	0	0	0	0	0	0	0	148,166	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(122,625)	9,673	131,698	0	0	0	0	0	0	0	0	18,746	45

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10a	Physical Therapy	$ 256,152	TruRehab, LLC	100.00%	$ 201,028	$ (55,124)	1
2	V	10a	Occupational Therapy	289,750	TruRehab, LLC	100.00%	227,396	(62,354)	2
3	V	10a	Speech Therapy	21,874	TruRehab, LLC	100.00%	17,167	(4,707)	3
4	V	10a	Therapy Management	63,494	TruRehab, LLC	100.00%	49,830	(13,664)	4
5	V								5
6	V	21	Clerical and General		Davis Ide HCP		1,725	1,725	6
7	V	32	Interest		Davis Ide HCP		36,421	36,421	7
8	V	34	Rent	240,000	Davis Ide HCP		347,376	107,376	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 871,270			$ 880,943	$ * 9,673	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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Ide Management Group LLC	100.00%	$ 2,768	$ 2,768	15
16	V	10	Nursing		Ide Management Group LLC	100.00%	30,000	30,000	16
17	V	19	Professional Fees		Ide Management Group LLC	100.00%	5,783	5,783	17
18	V	20	Dues, Fees, Subscriptions		Ide Management Group LLC	100.00%			18
19	V	21	Clerical and General		Ide Management Group LLC	100.00%	151,843	151,843	19
20	V	22	Employee Benefits		Ide Management Group LLC	100.00%	34,345	34,345	20
21	V	24	Travel and Seminar		Ide Management Group LLC	100.00%	19,161	19,161	21
22	V	26	Insurance		Ide Management Group LLC	100.00%	(617)	(617)	22
23	V	30	Depreciation		Ide Management Group LLC	100.00%	2,417	2,417	23
24	V	32	Interest		Ide Management Group LLC	100.00%	5,998	5,998	24
25	V								25
26	V	21	Management Fees	120,000	Ide Management Group LLC	100.00%		(120,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,000			$ 251,698	$ * 131,698	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: 01/01/17 Ending: 12/31/17

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	50	Cathedral Health Care Center	Jasper IN	Ide Mgmt Group	Indianapolis IN	Management	1
2	Michael Sorrells	25	Chesterton Manor	Chesterton IN	TruRehab LLC	Vincennes IN	Rehab Therapies	2
3	Ashok Moran	25	Cloverleaf Healthcare	Knightsville IN	Davis-Ide HC Prop	Indianapolis IN	Property Mgmt	3
4			Colonial Nursing & Rehab	Crown Point IN				4
5			Kendallville Manor	Kendallville IN				5
6			Madison Health Care Center	Indianapolis IN				6
7			Oak Village	Oakton IN				7
8			River Terrace Retirement Community	Bluffton IN				8
9			Silver Memories Health Care	Versailles IN				9
10			Warsaw Meadows	Warsaw IN				10
11			Woodland Manor	Elkhart IN				11
12			Yorkton Manor	Yorktown IN				12
13			Edwardsville Nursing and Rehabilitation	Edwardsville IL				13
14			Newton Care Center	Newton IL				14
15			North Logan Health Care Center	Danville IL				15
16			Paris Healthcare Center	Paris IL				16
17			University Nursing and Rehab	Edwardsville IL				17
18			Countryside Health Care Center	Sioux City IA				18
19			Eagle Point Health Care Center	Clinton IA				19
20			Keosauqua Health Care Center	Keosauqua IA				20
21			Keota Health Care Center	Keota IA				21
22			Newton Health Care Center	Newton IA				22
23			Sigourney Health Care	Sigourney IA				23
24			Urbandale Health Care Center	Urbandale IA				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2.27	5.68	Alloc Salary	$ 19,881	21-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,881		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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Ide Management Group, LLC
Street Address: 4521 Independence Square
City / State / Zip Code: Indianapolis, IN 46203
Phone Number: (317-744-9148
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Inpatient Days	553,224	22	$ 48,729	$	31,424	$ 2,768	1
2	10	Nursing	Inpatient Days	553,224	22	528,158	528,158	31,424	30,000	2
3	19	Professional Fees	Inpatient Days	553,224	22	101,802		31,424	5,783	3
4	20	Dues, Fees, Subscriptions	Inpatient Days	553,224	22	0		31,424	0	4
5	21	Clerical and General	Inpatient Days	553,224	22	2,673,220	2,656,119	31,424	151,843	5
6	22	Employee Benefits	Inpatient Days	553,224	22	604,640		31,424	34,345	6
7	24	Travel and Seminar	Inpatient Days	553,224	22	337,331		31,424	19,161	7
8	26	Insurance	Inpatient Days	553,224	22	(10,862)		31,424	(617)	8
9	30	Depreciation	Inpatient Days	553,224	22	42,543		31,424	2,417	9
10	32	Interest	Inpatient Days	553,224	22	105,593		31,424	5,998	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,431,154	$ 3,184,277		$ 251,698	25

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 119,180	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).		$ (30,577)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 148,653	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.		$ 118,076	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	97,947	8
	2013	88,603	9
	2014	88,486	10
	2015	56,302	11
	2016	88,603	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 Paul Traczek

TELEPHONE 715-858-6619 FAX #: 715-832-2345

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-06-411-006-0060	Nursing Home	$ 86,902.80	$ 86,902.80
2.	23-06-411-011-0060	Nursing Home	$ 850.02	$ 850.02
3.	23-06-411-012-0060	Nursing Home	$ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/17 Ending: 12/31/17

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. [ ] (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 North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	693	20	693		10,043	9
10	Various			2005	29,957	1,498	20	1,498		20,138	10
11	Various			2006	8,930	447	20	447		5,361	11
12	Various			2007	610	20	20	20		610	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: 01/01/17 Ending: 12/31/17

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	$ 27	20	$ 27	$	$ 268	37
38	New Secure Care Key Pad	2008	1,657	83	20	83		829	38
39	Wallpapering	2008	1,036	52	20	52		519	39
40	Wallpapering	2008	1,455	73	20	73		729	40
41	Install Remote Generator Annuciator Panel	2008	3,641	182	20	182		1,820	41
42	P&G Pump Housing Repair and Upgrade	2008	3,145	157	20	157		1,570	42
43	Holby Mixing Valve - Boiler Repair	2009	3,114	156	20	156		1,403	43
44	Room renocations - Paintwork	2009	3,698	185	20	185		1,665	44
45	Heater Booster	2010	2,915	146	20	146		1,167	45
46	Awning	2011	3,385	169	20	169		1,183	46
47	Fire Alarm System	2011	9,335	467	20	467		3,269	47
48	Fire Alarm Inspection	2011	3,041	152	20	152		1,064	48
49	Two Shunt Trip Breakers	2011	2,950	148	20	148		1,036	49
50	Generator Starter Replaced	2011	3,581	179	20	179		1,253	50
51	Main Sign Relocation	2013	4,970	497	10	497		2,154	51
52	Plumbing Installed Backflows on Pipes	2013	5,378	215	25	215		878	52
53	1st Floor Dining Room, Conference Room,	2013	67,452	4,497	15	4,497		18,363	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	2,185	10	2,185		8,194	59
60	Booster Heater C15 208V, 3PH (HATCO)	2014	2,235	224	10	224		840	60
61	New carpet	2014	4,450	890	5	890		3,338	61
62	Water Heater and tempering valve replaced	2014	11,230	1,123	10	1,123		4,211	62
63	Circulator pumps for boiler	2014	3,950	395	10	395		1,251	63
64	Install door restrictions elevator	2014	5,460	364	15	364		1,153	64
65	New contactor for air conditioner	2014	4,236	424	10	424		1,343	65
66	New condenser for air conditioner	2014	4,677	312	15	312		988	66
67	Duct work	2014	1,172	59	20	59		187	67
68	Air conditioner work	2014	5,924	846	7	846		2,679	68
69	Installed two new valves on boiler and water heater	2014	3,474	347	10	347		1,099	69
70	TOTAL (lines 4 thru 69)		$ 243,301	$ 17,212		$ 17,212	$	$ 100,605	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: 01/01/17 Ending: 12/31/17

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	$ 17,212		$ 17,212	$	$ 100,605	1
2	Curtain rods and Drages	2014	10,216	1,022	10	1,022		3,236	2
3	Premium Faux wood blinds	2014	8,842	884	10	884		2,799	3
4	Curtain rods and Drages	2014	2,009	201	10	201		636	4
5	New signs throughout building (stairwell, restroom,	2014	5,919	395	15	395		1,251	5
6	common room, etc.)								6
7	Flooring - Armstrong - ceramic tile in the bathrooms	2015	1,564	78	20	78		202	7
8	120 Capacity Pellet Heater	2015	5,035	252	20	252		588	8
9	20 Amp Inducstrial Pole Switch	2015	529	26	20	26		76	9
10	Secure Care Door Access Control	2015	15,797	790	20	790		2,370	10
11	Floor Care 14 Rooms	2015	2,279	114	20	114		314	11
12	Awning	2015	5,482	274	20	274		822	12
13	Exterior Doors	2015	27,500	1,375	20	1,375		2,979	13
14	Flooring - vinyl plank flooring throughout facility	2015	93,640	4,682	20	4,682		10,925	14
15	Key Pad - Delayed Egress Controller	2015	3,558	178	20	178		445	15
16	Cicvuit/Outlet for New Kiosks	2015	1,846	92	20	92		207	16
17	Total renovation of facility incl: remodel of all resident rooms,	2015	1,052,314	52,616	20	52,616		114,395	17
18	addition of 2 therapy gyms & therapy room								18
19									19
20	Grate	2016	1,088	50	20	50		100	20
21	Breaker	2016	678	20	20	20		40	21
22	Side Walk Lifted	2016	600	23	20	23		46	22
23	Exhaust Fan Kitchen	2016	2,420	61	20	61		122	23
24	Total renovation of facility incl: remodel of all resident rooms,	2016	50,000	2,500	20	2,500		5,000	24
25	addition of 2 therapy gyms & therapy room								25
26									26
27	Prior year adjustment		(38,901)	(1,596)			1,596	(20,560)	27
28									28
29	Repair Limestone	2017	1,994	75	20	75		75	29
30	Repair Limestone	2017	2,074	78	20	78		78	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,499,784	$ 81,402		$ 82,998	$ 1,596	$ 226,751	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: 01/01/17 Ending: 12/31/17

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	$ 447,884	$ 56,795	$ 58,245	$ 1,450	Various	$ 201,382	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	52,053					40,483	73
74								74
75	TOTALS	$ 499,937	$ 56,795	$ 58,245	$ 1,450		$ 241,865	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	Patient Transportation	2011 Ford E350	2015	$ 41,650	$ 8,330	$ 8,330	$	5	$ 24,990	76
77										77
78										78
79										79
80	TOTALS			$ 41,650	$ 8,330	$ 8,330	$		$ 24,990	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)	$ 2,041,371	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,527	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,573	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,046	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 493,606	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: 01/01/17 Ending: 12/31/17

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	11/1/03	$ 240,000	21	20	3
4	Additions							4
5								5
6								6
7	TOTAL		108		$ 240,000 **			7

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

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

10. Effective dates of current rental agreement:
Beginning 11/1/03
Ending 12/31/24

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2018	$ 357,798
13.	12/31/2019	$ 368,532
14.	12/31/2020	$ 379,266

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 34,007 Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	5,562	$ 289,750	$	5,562	$ 289,750	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		305	21,874		305	21,874	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,947	256,152		3,947	256,152	4
5	Physician Care	39-3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				148,621		148,621	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					12,728		12,728	12
13	Other (specify): X-Ray	39-3					1,985		1,985	13
14	TOTAL			$	9,814	$ 567,776	$ 163,334	9,814	$ 731,110	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:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 49,612	$	1
2	Cash-Patient Deposits	56,647		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	823,555		3
4	Supply Inventory (priced at)	9,967		4
5	Short-Term Investments			5
6	Prepaid Insurance	(41,743)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 898,038	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,850		13
14	Buildings, at Historical Cost	1,415,922		14
15	Leasehold Improvements, at Historical Cost	57,944		15
16	Equipment, at Historical Cost	607,845		16
17	Accumulated Depreciation (book methods)	(492,193)		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)**	$ 1,611,368	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,509,406	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,967,208	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,647		28
29	Short-Term Notes Payable	170,325		29
30	Accrued Salaries Payable	(321)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(114,554)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,076		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Legal Contingency	102,765		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,300,146	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,300,146	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 209,260	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,509,406	$	48

***(See instructions.)**

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 680,901	1
2	Restatements (describe):	(207,813)	2
3	**Prior Period Adjustment**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 473,088	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(263,828)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (263,828)	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)**	$ 209,260	24 *

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 4,670,320	1
2	Discounts and Allowances for all Levels	(3,941)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,666,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,026,012	6
7	Oxygen	40,547	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,066,559	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	104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	147,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,915	19
20	Radiology and X-Ray	765	20
21	Other Medical Services	866	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,755	23
	D. Non-Operating Revenue		
24	Contributions	182	24
25	Interest and Other Investment Income***	4,777	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,959	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	3,217	28
28a	Misc. Income	12,784	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,001	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,912,653	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	954,344	31
32	Health Care	3,069,072	32
33	General Administration	1,281,647	33
	B. Capital Expense		
34	Ownership	538,508	34
	C. Ancillary Expense		
35	Special Cost Centers	163,334	35
36	Provider Participation Fee	169,576	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,176,481	40
41	**Income before Income Taxes (line 30 minus line 40)****	(263,828)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (263,828)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,513,312	44
45	Private Pay - Net Inpatient Revenue	1,150,126	45
46	Medicare - Net Inpatient Revenue	752,559	46
47	Other-(specify) Managed Care - Net Inpatient Revenue	250,382	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,666,379	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	2,093	2,093	$ 82,633	$ 39.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,772	18,746	555,031	29.61	3
4	Licensed Practical Nurses	18,150	18,895	461,171	24.41	4
5	CNAs & Orderlies	64,666	67,332	891,696	13.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,012	5,277	59,361	11.25	9
10	Activity Assistants					10
11	Social Service Workers	1,991	2,217	44,528	20.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,724	16,981	191,721	11.29	15
16	Dishwashers					16
17	Maintenance Workers	4,150	4,410	81,024	18.37	17
18	Housekeepers	11,105	11,491	110,448	9.61	18
19	Laundry	6,335	6,672	62,143	9.31	19
20	Administrator	2,320	2,368	81,050	34.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,691	6,213	171,412	27.59	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	1,885	2,191	43,371	19.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,894	164,886	$ 2,835,589 *	$ 17.20	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	410	$ 20,219	1-3	35
36	Medical Director	480	24,000	9-3	36
37	Medical Records Consultant	242	2,484	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	113	6,757	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	4	255	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,248	$ 53,715		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
Dreher	Administrator		$ 81,050
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,050

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BKD	Accounting	$ 8,978
Saikley, Garrison, Col. & Barney	Legal	715
Drewry Simmons Vornehm, LLP	Legal	44
Myers Carden & & Sax LLC	Legal	4,551
Hepler Broom LLC	Legal	1,352
City of Danville	Legal	186
Capstone Retirement Group	Legal	1,500
Parrish Consulting Services, Inc.	Technology	14,655
Integrated Resources Mgmt.	Payroll	84,966
Outcome Services of IL, INC.	Professional	923
Ide Management Group	Professional/Mgmt.	120,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 237,870

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,167
Unemployment Compensation Insurance	45,811
FICA Taxes	211,574
Employee Health Insurance	143,462
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	5,414
Employee Physicals	3,180
Human Resources	73
Ide Management Group	34,345
TOTAL (agree to Schedule V, line 22, col.8)	$ 535,026

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,807
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	4,025
Dues and Subscriptions	143
License and Permits	4,291
Advertising expense	21,608
Ide Management Group	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,874

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	8,425
Seminar Expense	
Education	8,786
Hotel	6,138
Ide Management Group	19,161
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 42,510

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 01/01/17 Ending: 12/31/17

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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,062** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **169,576**
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? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees