



Facility Name & ID Number Paris Health Care Ctr

# 0046565 Report Period Beginning: 1/1/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,848</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,414</u>	<u>7,048</u>	<u>5,304</u>	<u>30,766</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,414</u>	<u>7,048</u>	<u>5,304</u>	<u>30,766</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.67%

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

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

YES  NO

I. On what date did you start providing long term care at this location?

Date started 1/1/2004

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 1/1/2004 NO

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

YES  NO  If YES, enter number of beds certified 128 and days of care provided 3,709

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name &amp; ID Number

Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	167,293	12,899	8,501	188,693		188,693		188,693		1
2	Food Purchase		194,160		194,160		194,160	(442)	193,718		2
3	Housekeeping	102,344	19,594		121,938		121,938		121,938		3
4	Laundry	64,080	15,735	242	80,057		80,057		80,057		4
5	Heat and Other Utilities			170,497	170,497		170,497		170,497		5
6	Maintenance	54,555	14,048	77,687	146,290		146,290	32	146,322		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	388,272	256,436	256,927	901,635		901,635	(410)	901,225		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,670	7,670		7,670		7,670		9
10	Nursing and Medical Records	1,533,449	127,538	13,567	1,674,554		1,674,554		1,674,554		10
10a	Therapy		2,822	5,328	8,150		8,150		8,150		10a
11	Activities	78,887	4,233	5,448	88,568		88,568		88,568		11
12	Social Services	73,555	1,388	1,938	76,881		76,881	(31,010)	45,871		12
13	CNA Training										13
14	Program Transportation			650	650		650		650		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,685,891	135,981	34,601	1,856,473		1,856,473	(31,010)	1,825,463		16
	<b>C. General Administration</b>										
17	Administrative	81,860			81,860		81,860	61,696	143,556		17
18	Directors Fees										18
19	Professional Services			164,458	164,458		164,458	52,054	216,512		19
20	Dues, Fees, Subscriptions & Promotions			33,963	33,963		33,963	(15,657)	18,306		20
21	Clerical & General Office Expenses	116,260	18,238	67,581	202,079		202,079	28,405	230,484		21
22	Employee Benefits & Payroll Taxes			411,010	411,010		411,010		411,010		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,130	3,130		3,130	20,308	23,438		24
25	Other Admin. Staff Transportation			14,333	14,333		14,333	(5,862)	8,471		25
26	Insurance-Prop.Liab.Malpractice			69,657	69,657		69,657		69,657		26
27	Other (specify):*							26,963	26,963		27
28	<b>TOTAL General Administration</b>	198,120	18,238	764,132	980,490		980,490	167,907	1,148,397		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,272,283	410,655	1,055,660	3,738,598		3,738,598	136,487	3,875,085		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 &amp; ID Number

Paris Health Care Ctr

#0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			31,679	31,679		31,679	(8,329)	23,350			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,917	43,917		43,917	(2,161)	41,756			32
33	Real Estate Taxes			71,567	71,567		71,567		71,567			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	47,767	227,767			34
35	Rent-Equipment & Vehicles			37,638	37,638		37,638	1,257	38,895			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			364,801	364,801		364,801	38,534	403,335			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		221,756	425,864	647,620		647,620	(8,512)	639,108			39
40	Barber and Beauty Shops			78	78		78		78			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			238,416	238,416		238,416		238,416			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		221,756	664,358	886,114		886,114	(8,512)	877,602			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,272,283	632,411	2,084,819	4,989,513		4,989,513	166,509	5,156,022			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 Paris Health Care Ctr

# 0046565

Report Period Beginning: 1/1/12

Ending: 12/31/12

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(222)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,714)	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	(8,329)	30		9
10	Interest and Other Investment Income	(2,161)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(220)	2		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	(474)	24		19
20	Contributions	(50)	21		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	(16,303)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(91)	20		28
29	Other-Attach Schedule	(28,822)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (65,386)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	231,895		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 231,895		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 166,509		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

Paris Health Care Ctr

ID# 0046565

Report Period Beginning: 1/1/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	BANK CHARGES	\$ (3,247)	21	1
2	MARKETING SALARIES	(31,010)	12	2
3	NONALLOWABLE TRAVEL	(5,862)	25	3
4	LATE FEES AND CHARGES	(28,949)	21	4
5	MISCELLANEOUS INCOME	(5,053)	21	5
6	ADJUST LEASE EXPENSE TO ACTUAL	45,299	34	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(28,822)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	Operating Expenses	PAGES 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(442)	0	0	0	0	0	0	0	0	0	0	(442)	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	32	0	0	0	0	0	0	0	0	32	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(442)</b>	<b>0</b>	<b>32</b>	<b>0</b>	<b>(410)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	(31,010)	0	0	0	0	0	0	0	0	0	0	(31,010)	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	<b>TOTAL Health Care and Programs</b>	<b>(31,010)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(31,010)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	61,696	0	0	0	0	0	0	0	0	61,696	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	52,054	0	0	0	0	0	0	0	0	52,054	19
20	Fees, Subscriptions & Promotions	(16,394)	0	737	0	0	0	0	0	0	0	0	(15,657)	20
21	Clerical & General Office Expenses	(46,013)	0	74,418	0	0	0	0	0	0	0	0	28,405	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	(474)	0	20,782	0	0	0	0	0	0	0	0	20,308	24
25	Other Admin. Staff Transportation	(5,862)	0	0	0	0	0	0	0	0	0	0	(5,862)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	26,963	0	0	0	0	0	0	0	0	26,963	27
28	<b>TOTAL General Administration</b>	<b>(68,743)</b>	<b>0</b>	<b>236,650</b>	<b>0</b>	<b>167,907</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(100,195)</b>	<b>0</b>	<b>236,682</b>	<b>0</b>	<b>136,487</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	(8,329)	0	0	0	0	0	0	0	0	0	0	(8,329)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,161)	0	0	0	0	0	0	0	0	0	0	(2,161)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	45,299	0	2,468	0	0	0	0	0	0	0	0	47,767	34
35	Rent-Equipment & Vehicles	0	0	1,257	0	0	0	0	0	0	0	0	1,257	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>34,809</b>	<b>0</b>	<b>3,725</b>	<b>0</b>	<b>38,534</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(8,512)	0	0	0	0	0	0	0	0	0	(8,512)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>(8,512)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,512)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(65,386)	(8,512)	240,407	0	0	0	0	0	0	0	0	166,509	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE 6-SUPPLEMENTAL		SEE 6-SUPPLEMENTAL		SEE 6-SUPPLEMENTAL		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	39 PHYSICAL THERAPY	\$ 196,500	TRU REHAB, LLC	100.00%	\$ 192,570	\$ (3,930)	1
2	V	39 OCCUPATIONAL THERAPY	143,333	TRU REHAB, LLC	100.00%	140,466	(2,867)	2
3	V	39 SPEECH THERAPY	49,770	TRU REHAB, LLC	100.00%	48,775	(995)	3
4	V	39 THERAPY MANAGEMENT FEE	36,000	TRU REHAB, LLC	100.00%	35,280	(720)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 425,603			\$ 417,091	\$ * (8,512)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	IDE MANAGEMENT GROUP, LLC	100.00%	\$		15
16	V	6 MAINTENANCE		IDE MANAGEMENT GROUP, LLC	100.00%	32	32	16
17	V	10 NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17 ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	61,696	61,696	18
19	V	19 PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	52,054	52,054	19
20	V	20 DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	737	737	20
21	V	21 CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	74,418	74,418	21
22	V	24 TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	20,782	20,782	22
23	V	25 TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26 INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%			24
25	V	27 EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	26,963	26,963	25
26	V	32 INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%			26
27	V	34 RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	2,468	2,468	27
28	V	35 RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	1,257	1,257	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		\$			\$ 240,407	\$ * 240,407	39

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

Facility Name &amp; ID Number

Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MARK IDE	100%	GRINNELL HEALTH CARE CENTER	GRINNELL, IA	IDE MANAGEMENT GROUP, LLC	GREENFIELD, IN	BOOKKEEPING/MGT	1
2			NEWTON HEALTH CARE CENTER	NEWTON, IA	TRU REHAB, LLC	VINCENNES, IN	THERAPY-REHAB	2
3			URBANDALE HEALTH CARE CENTER	URBANDALE, IA	DAVIS IHC PROP	GREENFIELD, IN	PROPERTY MGT	3
4			ZEARING HEALTH CARE CENTER	ZEARING, IA				4
5			CLOVERLEAF OF KNIGHTSVILLE	KNIGHTSVILLE, IN				5
6			COLONIAL HEALTH CARE	CROWN POINT, IN				6
7			WILLOW MANOR	VINCENNES, IN				7
8			KENDALLVILLE MANOR	KENDALVILLE, IN				8
9			LANDMARK HEALTHCARE	NEW ALBANY, IN				9
10			NORTH RIDGE ASSISTED LIVING (ALF)	ALBION, IN				10
11			NORTH RIDGE NURSING	ALBION, IN				11
12			RURAL HEALTHCARE	INDIANAPOLIS, IN				12
13			SUGAR CREEK REHAB	GREENFIELD, IN				13
14			THE CHATEAU AT SUGAR CREEK (ALF)	GREENFIELD, IN				14
15			WARSAW MEADOWS	WARSAW, IN				15
16			WOODLAND MANOR	ELKHART, IN				16
17			MADISON HEALTH CARE CENTER	INDIANAPOLIS, IN				17
18			BLOOMINGTON NURSING AND REHAB	BLOOMINGTON, IN				18
19			CORYDON NURSING AND REHAB	CORYDON, IN				19
20			ESSEX NURSING AND REHAB	LEBANON, IN				20
21			HIGHLAND NURSING AND REHAB	HIGHLAND, IN				21
22			LINTON NURSING AND REHAB	LINTON, IN				22
23			MERIDIAN NURSING AND REHAB	INDIANAPOLIS, IN				23
24			ROCKVILLE NURSING AND REHAB	ROCKVILLE, IN				24
25			TERRE HAUTE NURSING AND REHAB	TERRE HAUTE, IN				25
26			APPLETON HEALTH CARE CENTER	APPLETON, WI				26
27			UNIVERSITY NSG & REHAB CTR	EDWARDSVILLE, IL				27
28			NORTH LOGAN HEALTH CARE	DANVILLE, IL				28
29			EDWARDSVILLE NSG & REHAB CTR	EDWARDSVILLE, IL				29
30								30

Facility Name & ID Number Paris Health Care Ctr # 0046565 Report Period Beginning: 1/1/12 Ending: 12/31/12

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARK IDE	SHAREHOLDER	Administrative	100.00	SEE ATTACHED	2	5.00	Alloc Salary	\$ 5,755	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	\$ 5,755		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 Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INPATIENT DAYS	525,604	28	\$	\$ 30,756	\$ 0	1
2	6	MAINTENANCE	INPATIENT DAYS	525,604	28	540	30,756	32	2
3	10	NURSING	INPATIENT DAYS	525,604	28		30,756	0	3
4	17	ADMINISTRATIVE	INPATIENT DAYS	525,604	28	1,054,346	1,054,346	61,696	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	525,604	28	889,583	30,756	52,054	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	525,604	28	12,587	30,756	737	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	525,604	28	1,271,766	783,963	74,418	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	525,604	28	355,145	30,756	20,782	8
9	25	TRANSPORTATION	INPATIENT DAYS	525,604	28		30,756	0	9
10	26	INSURANCE	INPATIENT DAYS	525,604	28		30,756	0	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	525,604	28	460,777	30,756	26,963	11
12	32	INTEREST	INPATIENT DAYS	525,604	28		30,756	0	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	525,604	28	42,181	30,756	2,468	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	525,604	28	21,487	30,756	1,257	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,108,412	\$ 1,838,309		\$ 240,407	25

Facility Name & ID Number Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	PHYSICAL THERAPY						\$ 192,570	1
2	39	OCCUPATIONAL THERAPY						140,466	2
3	39	SPEECH THERAPY						48,775	3
4	39	THERAPY MGT FEES						35,280	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				\$	\$		\$ 417,091	25

Facility Name & ID Number

Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

**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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6	IMG	X		WORKING CAPITAL				629,122			43,917						
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$	\$ 629,122			\$ 43,917						
	<b>B. Non-Facility Related*</b>																
10	INTEREST INCOME		X								(2,161)						
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (2,161)						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 629,122			\$ 41,756						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # X

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2011 report.		\$	<b>77,411</b>		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.)		\$	<b>74,489</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,922)</b>		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>74,489</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>71,567</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<b>72,526</b>			8
	2008	<b>77,121</b>			9
	2009	<b>76,985</b>			10
	2010	<b>77,411</b>			11
	2011	<b>74,489</b>			12
	<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.**

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Paris Health Care Ctr COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0046565

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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-13-36-100-021</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>74,488.98</u>	\$ <u>74,488.98</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>74,488.98</u></u>	\$ <u><u>74,488.98</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

Facility Name & ID Number Paris Health Care Ctr

# 0046565 Report Period Beginning:

1/1/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,377 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		2004	34,257		20	1,713	1,713	15,416	9
10	Various		2005	12,194		20	610	610	4,480	10
11	Various		2006	19,032		20	952	952	6,662	11
12	Various		2007	45,484		20	2,274	2,274	12,219	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 Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	22 Wooden Shadow Boxes	2008	1,210		20	61	61	303	38
39	New Wiring	2008	1,550		20	78	78	388	39
40	New Water Heater	2008	8,843		20	442	442	2,211	40
41	Painting	2008	4,000		20	200	200	1,000	41
42	New Flooring	2009	28,195		20	1,410	1,410	5,639	42
43	Air Compressor	2009	3,702		20	185	185	740	43
44	A/C Unit / Air Handler	2010	5,906		20	295	295	886	44
45	Parking Lot Improvement	2010	7,375		20	369	369	1,107	45
46	7 1/2 Ton Air Handler	2011	11,350		20	568	568	1,136	46
47	Renovations	2011	9,257		20	463	463	926	47
48	Firewall Buildout	2011	8,800		20	440	440	880	48
49	Chair Rail	2011	8,340		20	417	417	834	49
50	Re-Route Water Main and Install Water Softener Head	2011	2,850		20	143	143	286	50
51	Rewire Several Rooms	2011	8,122		20	406	406	812	51
52				18,149			(18,149)		52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 220,467	\$ 18,149		\$ 11,026	\$ (7,123)	\$ 55,925	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 84,309	\$ 6,262	\$ 8,431	\$ 2,169	10	\$ 39,023	71
72	Current Year Purchases	37,359		108	108	10	108	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 121,668	\$ 6,262	\$ 8,539	\$ 2,277		\$ 39,131	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		VAN	2012	\$ 20,188	\$ 7,268	\$ 3,785	\$ (3,483)	4	\$ 3,785	76
77										77
78										78
79										79
80	TOTALS			\$ 20,188	\$ 7,268	\$ 3,785	\$ (3,483)		\$ 3,785	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)	\$ 362,323	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,679	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,350	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,329)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 98,841	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: OMEGA HEALTHCARE INVESTORS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>225,299</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>225,299</u>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2013                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 37,638 Description: Therapy equip 1,950; Dish machine 3,709; Copiers 14,810; postage meter 1,675; Med equip 15,494

(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	<b>TOTAL</b>		\$ _____	\$ _____	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 Paris Health Care Ctr # 0046565 Report Period Beginning: 1/1/12 Ending: 12/31/12  
**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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.)**

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$	3,262	\$ 143,333	\$	3,262	\$ 143,333	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		1,438	49,770		1,438	49,770	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		4,012	196,500		4,012	196,500	4
5	Physician Care		visits			113			113	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				178,350		178,350	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab &amp; X-ray</u>	39-02					43,406		43,406	12
13	Other (specify): <u>Ambulance / Therapy Fees</u>					36,148			36,148	13
14	<b>TOTAL</b>			\$	8,712	\$ 425,864	\$ 221,756	8,712	\$ 647,620	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.

Facility Name & ID Number Paris Health Care Ctr# 0046565Report Period Beginning: 1/1/12

Ending:

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## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (262)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,118,406		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,288		6
7	Other Prepaid Expenses	48,984		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,184,416	\$	10
	<b>B. Long-Term Assets</b>			
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	162,771		15
16	Equipment, at Historical Cost	141,856		16
17	Accumulated Depreciation (book methods)	(134,144)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 170,483	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,354,899	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 929,050	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,007		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,195		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,078		32
33	Accrued Interest Payable	97,145		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Expenses/NP	631,569		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,845,044	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,845,044	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (490,145)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,354,899	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (539,232)	1
2	Restatements (describe):		2
3	ROUNDING	(4)	3
4	AUDIT ADJUSTMENTS TO R/E	(84,416)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (623,652)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(184,327)	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	(70,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Member's Contribution	387,834	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 133,507	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (490,145)	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,628,378	1
2	Discounts and Allowances for all Levels	(847,760)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,780,618</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	805,502	6
7	Oxygen	20,426	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 825,928</b>	8
<b>C. Other Operating Revenue</b>			
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	2,425	13
14	Non-Patient Meals	222	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	145,155	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,406	19
20	Radiology and X-Ray		20
21	Other Medical Services	37,918	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 191,126</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,161	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,161</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS INCOME</b>	<b>5,053</b>	28
28a	<b>GAIN ON SALE OF ASSETS</b>	<b>300</b>	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,353</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,805,186</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	901,635	31
32	Health Care	1,856,473	32
33	General Administration	980,490	33
<b>B. Capital Expense</b>			
34	Ownership	364,801	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	647,698	35
36	Provider Participation Fee	238,416	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,989,513</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(184,327)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (184,327)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,980,711	44
45	Private Pay - Net Inpatient Revenue	1,152,079	45
46	Medicare - Net Inpatient Revenue	736,566	46
47	Other-(specify)		47
48	Other-(specify) <b>Part B, Bad Debts, Prior Year Income</b>	<b>(88,738)</b>	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 3,780,618</b>	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 Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,988	2,198	\$ 70,564	\$ 32.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,586	10,412	250,277	24.04	3
4	Licensed Practical Nurses	22,052	24,069	440,596	18.31	4
5	CNAs & Orderlies	59,714	63,448	772,012	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,628	7,815	78,887	10.09	10
11	Social Service Workers	4,002	4,117	73,555	17.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,575	16,647	167,293	10.05	15
16	Dishwashers					16
17	Maintenance Workers	4,013	4,200	54,555	12.99	17
18	Housekeepers	9,675	10,728	102,344	9.54	18
19	Laundry	6,817	7,297	64,080	8.78	19
20	Administrator	1,920	2,300	81,860	35.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,790	6,308	116,260	18.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,760	159,539	\$ 2,272,283 *	\$ 14.24	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	168	\$ 8,178	1.3	35
36	Medical Director	Monthly	7,670	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	Monthly	3,102	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	52	3,915	11.3	44
45	Social Service Consultant	26	1,938	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	246	\$ 24,803		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number Paris Health Care Ctr

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Susan Jester	ADMINISTRATOR		\$ 81,860	Workers' Compensation Insurance	\$ 19,894	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	9,746	
				FICA Taxes	255,833	Health Care Worker Background Check	1,489	
				Employee Health Insurance	126,164	(Indicate # of checks performed <u>30</u> )		
				Employee Meals		Patient Background Checks	87	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotion	16,394	
				Other Employee Benefits	9,119	Dues & Subscriptions	3,124	
						Licenses & Fees	3,210	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,860			Allocated from Ide Mgt	737	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	(16,303)	
			\$			Yellow page advertising	(91)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 411,010	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,306	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SEE ATTACHED SCHEDULE			\$ 164,458			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	3,130
							Allocation from Ide Mgt	20,782
							Entertainment Expense	(474)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 164,458	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 23,438

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Paris Health Care Ctr

# 0046565

Report Period Beginning:

1/1/12

Ending:

12/31/12

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (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. \$ 6,494 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES        NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES        NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 238,416  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation. See Attached Schedule  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.