

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,036	12,124	2,462	33,622	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,036	12,124	2,462	33,622	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.76%

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 01/01/2004

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 32 and days of care provided 2,462

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

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

Facility Name & ID Number

Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	181,545	12,353	7,920	201,818		201,818		201,818		1
2	Food Purchase		221,023		221,023		221,023	(256)	220,767		2
3	Housekeeping	137,900	28,924		166,824		166,824		166,824		3
4	Laundry	58,168	7,253		65,421		65,421		65,421		4
5	Heat and Other Utilities			115,284	115,284		115,284		115,284		5
6	Maintenance	59,495	21,175	42,722	123,392		123,392	144	123,536		6
7	Other (specify):*										7
8	TOTAL General Services	437,108	290,728	165,926	893,762		893,762	(112)	893,650		8
	B. Health Care and Programs										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	1,882,102	200,834	16,863	2,099,799		2,099,799		2,099,799		10
10a	Therapy		6,268	592	6,860		6,860		6,860		10a
11	Activities	49,864	4,958	9,225	64,047		64,047		64,047		11
12	Social Services	93,517	57		93,574		93,574	(36,485)	57,089		12
13	CNA Training										13
14	Program Transportation			852	852		852		852		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,025,483	212,117	69,532	2,307,132		2,307,132	(36,485)	2,270,647		16
	C. General Administration										
17	Administrative	84,384		60,000	144,384		144,384	10,413	154,797		17
18	Directors Fees										18
19	Professional Services			119,658	119,658		119,658	31,617	151,275		19
20	Dues, Fees, Subscriptions & Promotions			30,403	30,403		30,403	(14,269)	16,134		20
21	Clerical & General Office Expenses	127,275	24,783	34,841	186,899		186,899	200,807	387,706		21
22	Employee Benefits & Payroll Taxes			452,938	452,938		452,938		452,938		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,014	8,014		8,014	26,412	34,426		24
25	Other Admin. Staff Transportation			13,498	13,498		13,498	(850)	12,648		25
26	Insurance-Prop.Liab.Malpractice			29,069	29,069		29,069	3,663	32,732		26
27	Other (specify):*							50,395	50,395		27
28	TOTAL General Administration	211,659	24,783	748,421	984,863		984,863	308,188	1,293,051		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,674,250	527,628	983,879	4,185,757		4,185,757	271,591	4,457,348		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

#0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	
	D. Ownership											
30	Depreciation			15,982	15,982		15,982	10,376	26,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,159	48,159		48,159	(41,207)	6,952			32
33	Real Estate Taxes			75,786	75,786		75,786		75,786			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	277	240,277			34
35	Rent-Equipment & Vehicles			60,884	60,884		60,884	2,294	63,178			35
36	Other (specify):*											36
37	TOTAL Ownership			440,811	440,811		440,811	(28,260)	412,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,086	473,380	661,466		661,466	(14,095)	647,371			39
40	Barber and Beauty Shops			345	345		345		345			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,418	267,418		267,418		267,418			42
43	Other (specify):* X-ray & Lab Expense			48,570	48,570		48,570		48,570			43
44	TOTAL Special Cost Centers		188,086	789,713	977,799		977,799	(14,095)	963,704			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,674,250	715,714	2,214,403	5,604,367		5,604,367	229,236	5,833,603			45

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning: 1/1/14

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VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,376	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(256)	02		13
14	Non-Care Related Interest	(48,159)	32		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	(3,721)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,132)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,681)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,573)		\$	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	
		Amount	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)	319,809		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 319,809		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 229,236		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	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Edwardsville Nsg & Rehab Ctr

ID# 0046540

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	BANK CHARGES	\$ (2,463)	21	1
2	VENDING MACHINE	(556)	21	2
3	MISCELLANEOUS INCOME	(5,268)	21	3
4	MARKETING SALARY	(36,485)	12	4
5	MARKETING TRAVEL	(850)	25	5
6	ADJUST LEASE EXPENSE TO ACTUAL	(1,576)	34	6
7	OTHER DEPARTMENT EXPENSE	14,740	21	7
8	VENDOR SERVICE CHARGE	(15)	21	8
9	NON-ALLOWABLE LEGAL FEES	(208)	19	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		(32,681)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr# 0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(256)	0	0	0	0	0	0	0	0	0	0	(256)	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	144	0	0	0	0	0	0	0	0	144	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(256)	0	144	0	(112)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(36,485)	0	0	0	0	0	0	0	0	0	0	(36,485)	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	(36,485)	0	0	0	0	0	0	0	0	0	0	(36,485)	16
	C. General Administration													
17	Administrative	0	0	10,413	0	0	0	0	0	0	0	0	10,413	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(208)	0	31,825	0	0	0	0	0	0	0	0	31,617	19
20	Fees, Subscriptions & Promotions	(16,132)	0	1,863	0	0	0	0	0	0	0	0	(14,269)	20
21	Clerical & General Office Expenses	6,438	0	194,369	0	0	0	0	0	0	0	0	200,807	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	(3,721)	0	30,133	0	0	0	0	0	0	0	0	26,412	24
25	Other Admin. Staff Transportation	(850)	0	0	0	0	0	0	0	0	0	0	(850)	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,663	0	0	0	0	0	0	0	0	3,663	26
27	Other (specify):*	0	0	50,395	0	0	0	0	0	0	0	0	50,395	27
28	TOTAL General Administration	(14,473)	0	322,661	0	308,188	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,214)	0	322,805	0	271,591	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	10,376	0	0	0	0	0	0	0	0	0	0	10,376	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,159)	0	6,952	0	0	0	0	0	0	0	0	(41,207)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,576)	0	1,853	0	0	0	0	0	0	0	0	277	34
35	Rent-Equipment & Vehicles	0	0	2,294	0	0	0	0	0	0	0	0	2,294	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(39,359)	0	11,099	0	(28,260)	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	(14,095)	0	0	0	0	0	0	0	0	0	(14,095)	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	(14,095)	0	0	0	0	0	0	0	0	0	(14,095)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(90,573)	(14,095)	333,904	0	229,236	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	39 Physical Therapy	\$ 181,421	Tru Rehab, LLC	100.00%	\$ 175,805	\$ (5,616)	1
2	V	39 Occupational Therapy	191,111	Tru Rehab, LLC	100.00%	185,195	(5,916)	2
3	V	39 Speech Therapy	49,784	Tru Rehab, LLC	100.00%	48,243	(1,541)	3
4	V	39 Therapy Management Fee	33,000	Tru Rehab, LLC	100.00%	31,978	(1,022)	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		\$ 455,316			\$ 441,221	\$ * (14,095)	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%	144	144	16
17	V	10 NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17 ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	70,413	70,413	18
19	V	19 PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	31,825	31,825	19
20	V	20 DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	1,863	1,863	20
21	V	21 CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	194,369	194,369	21
22	V	24 TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	30,133	30,133	22
23	V	25 TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26 INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%	3,663	3,663	24
25	V	27 EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	50,395	50,395	25
26	V	32 INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%	6,952	6,952	26
27	V	34 RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	1,853	1,853	27
28	V	35 RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	2,294	2,294	28
29	V							29
30	V	17 MANAGEMENT FEES	60,000	IDE MANAGEMENT GROUP, LLC	100.00%		(60,000)	30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 60,000			\$ 393,904	\$ * 333,904	39

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

Facility Name & ID Number

Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MARK IDE	100%	KEOTA HEALTH CARE CENTER	KEOTA, IA				1
2			SIGOURNEY HEALTH CARE	SIGOURNEY, IA				2
3			UNIVERSITY NURSING & REHAB CENTER	EVANSVILLE, IN				3
4			UNIVERSITY NSG & REHAB CTR	EDWARDSVILLE, IL				4
5			PARIS HEALTHCARE CENTER	PARIS, IL				5
6			NORTH LOGAN HEALTH CARE	DANVILLE, IL				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 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	2.46	6.06%	Alloc Salary	\$ 21,211	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	\$ 21,211		13

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	554,738	35	\$	\$	33,594	\$ 0	1
2	6	MAINTENANCE	INPATIENT DAYS	554,738	35	2,382	33,594	144		2
3	10	NURSING	INPATIENT DAYS	554,738	35		33,594			3
4	17	ADMINISTRATIVE	INPATIENT DAYS	554,738	35	1,162,714	1,162,714	33,594	70,413	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	554,738	35	525,518	33,594	31,825		5
6	20	DUES, FEES, SUB	INPATIENT DAYS	554,738	35	30,772	33,594	1,863		6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	554,738	35	3,209,600	2,416,426	33,594	194,369	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	554,738	35	497,592	33,594	30,133		8
9	25	TRANSPORTATION	INPATIENT DAYS	554,738	35		33,594			9
10	26	INSURANCE	INPATIENT DAYS	554,738	35	60,487	33,594	3,663		10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	554,738	35	832,136	33,594	50,395		11
12	32	INTEREST	INPATIENT DAYS	554,738	35	114,803	33,594	6,952		12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	554,738	35	30,606	33,594	1,853		13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	554,738	35	37,880	33,594	2,294		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS				\$ 6,504,490	\$ 3,579,140		\$ 393,904		25

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	DIRECT ALLOCATION		\$	\$		\$ 175,805	1
2	39	OCCUPATIONAL THERAPY	DIRECT ALLOCATION					185,195	2
3	39	SPEECH THERAPY	DIRECT ALLOCATION					48,243	3
4	39	THERAPY MGT FEES	DIRECT ALLOCATION					31,978	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				\$	\$		\$ 441,221	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2013 report.		\$	73,717		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.)		\$	78,298		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	4,581		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	71,205		4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	75,786		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	74,401	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2010	75,786	9												
	2011	76,061	10												
	2012	77,580	11												
	2013	78,298	12												

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Edwardsville Nsg & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046540

CONTACT PERSON REGARDING THIS REPORT TYSEN ADAMS

TELEPHONE (317) 383-4000 FAX #: (317) 383-4200

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(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>10-1-16-07-00-000-019.003</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>78,298.00</u>	\$ <u>78,298.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>78,298.00</u></u>	\$ <u><u>78,298.00</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540 Report Period Beginning:

1/1/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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

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

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2004	5,848		20	292	292	3,215	9
10	Various		2005	9,368		20	468	468	5,406	10
11	Various		2006	25,252		20	1,263	1,263	12,168	11
12	Various		2007	10,551		20	528	528	4,222	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

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	New Roof	2008	\$ 4,200	\$	20	\$ 210	\$ 210	\$ 1,470	37
38	Rebuild Shower Stalls	2008	3,000		20	150	150	1,050	38
39	Rebuild Shower Stalls	2008	3,382		20	169	169	1,183	39
40	Hot Water Heater	2009	5,918		20	296	296	1,776	40
41	Cabinets & Countertops	2009	2,670		20	134	134	803	41
42	Hot Water Heater	2009	6,418		20	321	321	1,926	42
43	Lumber, Cabinets, Countertops, Window Treatments	2010	7,220		20	361	361	1,805	43
44	Concrete Work	2011	7,357		20	368	368	1,472	44
45	Concrete Work	2011	4,388		20	219	219	876	45
46	Roof Replacement	2013	22,325		10	2,233	2,233	2,977	46
47	Trash Enclosure	2013	3,604		15	240	240	260	47
48	Water Heater	2013	4,800		10	480	480	520	48
49	C Hall Res. Shower Room Floor/Wall Ceramic Tile Replacement	2013	9,000		20	450	450	488	49
50	12x16 Concrete patio with privacy fence	2014	2,700		15	30	30	30	50
51	Hot Water Heater	2014	1,690		10	127	127	127	51
52	Remodel entryway restroom ceramic tile, exhaust fan, paint	2014	1,400		20	52	52	52	52
53	New flat roof	2014	50,400		10	2,520	2,520	2,520	53
54									54
55									55
56				9,980			(9,980)		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)		\$ 191,491	\$ 9,980		\$ 10,911	\$ 931	\$ 44,346	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	\$ 152,068	\$ 5,762	\$ 15,207	\$ 9,445		\$ 90,801	71
72	Current Year Purchases	7,295	240	240			240	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 159,363	\$ 6,002	\$ 15,447	\$ 9,445		\$ 91,041	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 350,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,982	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,358	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,376	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 135,387	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>238,424</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>238,424</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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 60,884 Description: See Attachment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr # 0046540 Report Period Beginning: 1/1/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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	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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39.03	hrs	\$	3,939	\$ 191,111	\$	3,939	\$ 191,111	1	
2	Licensed Speech and Language Development Therapist	39.03	hrs		925	49,784		925	49,784	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39.03	hrs		3,515	181,421		3,515	181,421	4	
5	Physician Care	39.03	visits			97			97	5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39.02	# of prescrpts				187,211		187,211	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Ambulance, Therapy Fees</u>					50,967			50,967	12	
13	Other (specify): <u>Lab & X-Ray</u>	43.3				49,445			49,445	13	
14	TOTAL			\$	8,379	\$ 522,825	\$ 187,211	8,379	\$ 710,036	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 Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning: 1/1/14

Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 181,538	\$	1
2	Cash-Patient Deposits	39,573		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,192,812		3
4	Supply Inventory (priced at)	10,689		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,444		6
7	Other Prepaid Expenses	463		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,451,519	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	93,219		14
15	Leasehold Improvements, at Historical Cost	65,575		15
16	Equipment, at Historical Cost	159,363		16
17	Accumulated Depreciation (book methods)	(148,568)		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)	\$ 169,589	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,621,108	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,336,098	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,922		32
33	Accrued Interest Payable	99,551		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Legal Contingency / DP Fee	475,163		36
37	Resident Trust Fund Liability	39,573		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,021,307	\$	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)	\$ 4,021,307	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,400,199)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,621,108	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,115,547)	1
2	Restatements (describe):		2
3	CHANGE IN ACCUMULATED SURPLUS	5,916	3
4	CHANGE IN ADDITIONAL PAID-IN EQUITY	(108,276)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,217,907)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(182,299)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ROUNDING	7	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (182,292)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,400,199)	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,100,055	1
2	Discounts and Allowances for all Levels	(1,730,804)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,369,251	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	852,861	6
7	Oxygen	30,032	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 882,893	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	150,289	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,016	19
20	Radiology and X-Ray	561	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,866	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,234	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,234	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and Vending Income	5,824	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,824	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,422,068	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	893,762	31
32	Health Care	2,307,132	32
33	General Administration	984,863	33
B. Capital Expense			
34	Ownership	440,811	34
C. Ancillary Expense			
35	Special Cost Centers	710,381	35
36	Provider Participation Fee	267,418	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,604,367	40
41	Income before Income Taxes (line 30 minus line 40)**	(182,299)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (182,299)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,037,400	44
45	Private Pay - Net Inpatient Revenue	962,192	45
46	Medicare - Net Inpatient Revenue	586,262	46
47	Other-(specify) <u>Part B, Bad Debts, Prior Year Income</u>	(216,603)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,369,251	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 Edwardsville Nsg & Rehab Ctr

0046540

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,699	3,059	\$ 87,644	\$ 28.65	1
2	Assistant Director of Nursing	2,393	2,626	62,550	23.82	2
3	Registered Nurses	10,794	11,690	280,697	24.01	3
4	Licensed Practical Nurses	25,359	27,843	586,122	21.05	4
5	CNAs & Orderlies	62,245	68,158	820,556	12.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,070	4,609	49,864	10.82	10
11	Social Service Workers	4,383	4,799	93,517	19.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,771	17,789	181,545	10.21	15
16	Dishwashers					16
17	Maintenance Workers	3,522	3,870	59,495	15.37	17
18	Housekeepers	11,542	12,718	137,900	10.84	18
19	Laundry	5,326	5,842	58,168	9.96	19
20	Administrator	1,965	2,157	84,384	39.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,178	4,610	127,275	27.61	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	3,322	3,490	44,533	12.76	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,569	173,260	\$ 2,674,250 *	\$ 15.43	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	Monthly	\$ 7,920	1.3	35
36	Medical Director	Monthly	42,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	104	5,745	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	104	\$ 55,665		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Brian Koontz	Administrator		\$ 43,626	Workers' Compensation Insurance	\$ 80,636	IDPH License Fee	\$ 3,980		
Jessica Fritz	Administrator		40,758	Unemployment Compensation Insurance		Advertising: Employee Recruitment	90		
				FICA Taxes	267,763	Health Care Worker Background Check	6,562		
				Employee Health Insurance	107,670	(Indicate # of checks performed <u>32</u>)			
				Employee Meals		Patient Background Checks	66	2,146	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotions		16,132	
				Other Employee Benefits	(3,131)	Dues & Subscriptions		1,343	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,384			License & Fees		150	
B. Administrative - Other						Allocation from Ide Mgmt		1,863	
Description			Amount			Less: Public Relations Expense	(
Management Fees - Ide Management Group			\$ 60,000			Non-allowable advertising		(16,132)	
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 60,000			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,134	
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			\$ 119,658				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	8,014	
							Allocation from Ide Mgmt	30,133	
							Entertainment Expense	(3,721)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 119,658	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 34,426

* 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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Edwardsville Nsg & Rehab Ctr# 0046540Report Period Beginning: 1/1/14Ending: 12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,423 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. \$ 267,418
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%L14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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. YES
Attach invoices and a summary of services for all architect and appraisal fees.