

Facility Name & ID Number University Nsg & Rehab Ctr

0046557 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	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</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>122</u>	TOTALS	<u>122</u>	<u>44,530</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>21,419</u>	<u>9,555</u>	<u>2,199</u>	<u>33,173</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>21,419</u>	<u>9,555</u>	<u>2,199</u>	<u>33,173</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.50%

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 118 and days of care provided 2,199

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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

University Nsg & Rehab Ctr

0046557

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	194,874	16,392	8,430	219,696		219,696		219,696		1
2	Food Purchase		210,014		210,014		210,014	(299)	209,715		2
3	Housekeeping	57,136	19,983		77,119		77,119		77,119		3
4	Laundry	100,287	12,131		112,418		112,418		112,418		4
5	Heat and Other Utilities			168,457	168,457		168,457		168,457		5
6	Maintenance	47,584	13,403	50,418	111,405		111,405	142	111,547		6
7	Other (specify):*										7
8	TOTAL General Services	399,881	271,923	227,305	899,109		899,109	(157)	898,952		8
	B. Health Care and Programs										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	1,792,502	138,011	4,975	1,935,488		1,935,488		1,935,488		10
10a	Therapy		9,360		9,360		9,360		9,360		10a
11	Activities	48,259	6,789	4,368	59,416		59,416		59,416		11
12	Social Services	95,989	1,462	816	98,267		98,267	(41,089)	57,178		12
13	CNA Training										13
14	Program Transportation			3,846	3,846		3,846		3,846		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,936,750	155,622	53,005	2,145,377		2,145,377	(41,089)	2,104,288		16
	C. General Administration										
17	Administrative	99,375		25,000	124,375		124,375	44,529	168,904		17
18	Directors Fees										18
19	Professional Services			174,260	174,260		174,260	31,426	205,686		19
20	Dues, Fees, Subscriptions & Promotions			39,137	39,137		39,137	(18,232)	20,905		20
21	Clerical & General Office Expenses	111,797	13,597	40,846	166,240		166,240	170,129	336,369		21
22	Employee Benefits & Payroll Taxes			512,377	512,377		512,377		512,377		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,201	4,201		4,201	29,271	33,472		24
25	Other Admin. Staff Transportation			9,822	9,822		9,822	(2,719)	7,103		25
26	Insurance-Prop.Liab.Malpractice			49,921	49,921		49,921	3,618	53,539		26
27	Other (specify):*							49,761	49,761		27
28	TOTAL General Administration	211,172	13,597	855,564	1,080,333		1,080,333	307,783	1,388,116		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,547,803	441,142	1,135,874	4,124,819		4,124,819	266,537	4,391,356		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.

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			22,926	22,926			(912)	22,014			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,813	13,813			(6,948)	6,865			32
33	Real Estate Taxes			74,273	74,273				74,273			33
34	Rent-Facility & Grounds			300,000	300,000			(59,746)	240,254			34
35	Rent-Equipment & Vehicles			19,542	19,542			2,265	21,807			35
36	Other (specify):*											36
37	TOTAL Ownership			430,554	430,554			(65,341)	365,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,998	535,944	679,942			(16,224)	663,718			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,554	298,554				298,554			42
43	Other (specify):* X-Ray & Lab			13,918	13,918				13,918			43
44	TOTAL Special Cost Centers		143,998	848,416	992,414			(16,224)	976,190			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,547,803	585,140	2,414,844	5,547,787		5,547,787	184,972	5,732,759			45

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

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	(26,002)	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	(912)	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	(299)	02		13
14	Non-Care Related Interest	(13,813)	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	(1,805)	21		18
19	Entertainment	(485)	24		19
20	Contributions	(400)	20		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	(19,672)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(99,380)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (162,768)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	347,740		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 347,740		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 184,972		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

University Nsg & Rehab Ctr

ID# 0046557

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	BANK CHARGES	\$ (2,124)	21	1
2				2
3	MARKETING SALARY	(41,089)	12	3
4	MARKETING TRAVEL	(2,719)	25	4
5	OTHER DEPARTMENT EXPENSE	8,375	21	5
6	MISCELLANEOUS INCOME	(247)	21	6
7	ADJUST LEASE EXPENSE TO ACTUAL	(61,576)	34	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(99,380)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number University Nsg & Rehab Ctr# 0046557

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(299)	0	0	0	0	0	0	0	0	0	0	(299)	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	142	0	0	0	0	0	0	0	0	142	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(299)	0	142	0	(157)	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	(41,089)	0	0	0	0	0	0	0	0	0	0	(41,089)	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	(41,089)	0	0	0	0	0	0	0	0	0	0	(41,089)	16
	C. General Administration													
17	Administrative	0	0	44,529	0	0	0	0	0	0	0	0	44,529	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	31,426	0	0	0	0	0	0	0	0	31,426	19
20	Fees, Subscriptions & Promotions	(20,072)	0	1,840	0	0	0	0	0	0	0	0	(18,232)	20
21	Clerical & General Office Expenses	(21,803)	0	191,932	0	0	0	0	0	0	0	0	170,129	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	(485)	0	29,756	0	0	0	0	0	0	0	0	29,271	24
25	Other Admin. Staff Transportation	(2,719)	0	0	0	0	0	0	0	0	0	0	(2,719)	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,618	0	0	0	0	0	0	0	0	3,618	26
27	Other (specify):*	0	0	49,761	0	0	0	0	0	0	0	0	49,761	27
28	TOTAL General Administration	(45,079)	0	352,862	0	307,783	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(86,467)	0	353,004	0	266,537	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number University Nsg & Rehab Ctr

0046557

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 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)	
	D. Ownership													
30	Depreciation	(912)	0	0	0	0	0	0	0	0	0	0	(912)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,813)	0	6,865	0	0	0	0	0	0	0	0	(6,948)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(61,576)	0	1,830	0	0	0	0	0	0	0	0	(59,746)	34
35	Rent-Equipment & Vehicles	0	0	2,265	0	0	0	0	0	0	0	0	2,265	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(76,301)	0	10,960	0	(65,341)	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	(16,224)	0	0	0	0	0	0	0	0	0	(16,224)	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	(16,224)	0	0	0	0	0	0	0	0	0	(16,224)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(162,768)	(16,224)	363,964	0	184,972	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	\$ 212,710	Tru Rehab, LLC	100.00%	\$ 206,125	\$ (6,585)	1
2	V	39 Occupational Therapy	221,939	Tru Rehab, LLC	100.00%	215,069	(6,870)	2
3	V	39 Speech Therapy	51,951	Tru Rehab, LLC	100.00%	50,343	(1,608)	3
4	V	39 Therapy Management Fee	37,500	Tru Rehab, LLC	100.00%	36,339	(1,161)	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		\$ 524,100			\$ 507,876	\$ * (16,224)	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%	142	142	16
17	V	10 NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17 ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	69,529	69,529	18
19	V	19 PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	31,426	31,426	19
20	V	20 DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	1,840	1,840	20
21	V	21 CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	191,932	191,932	21
22	V	24 TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	29,756	29,756	22
23	V	25 TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26 INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%	3,618	3,618	24
25	V	27 EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	49,761	49,761	25
26	V	32 INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%	6,865	6,865	26
27	V	34 RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	1,830	1,830	27
28	V	35 RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	2,265	2,265	28
29	V							29
30	V	17 MANAGEMENT FEES	25,000	IDE MANAGEMENT GROUP, LLC	100.00%		(25,000)	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		\$ 25,000			\$ 388,964	\$ * 363,964	39

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

Facility Name & ID Number

University Nsg & Rehab Ctr

0046557

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number

University Nsg & Rehab Ctr

0046557

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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	2.42	6.06%	Alloc Salary	\$ 21,217	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	\$ 21,217		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 University Nsg & Rehab Ctr

0046557

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	\$	\$	33,173	\$	1
2	6	MAINTENANCE	INPATIENT DAYS	554,738	35	2,382		33,173	142	2
3	10	NURSING	INPATIENT DAYS	554,738	35			33,173		3
4	17	ADMINISTRATIVE	INPATIENT DAYS	554,738	35	1,162,714	1,162,714	33,173	69,529	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	554,738	35	525,518		33,173	31,426	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	554,738	35	30,772		33,173	1,840	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	554,738	35	3,209,600	2,416,426	33,173	191,932	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	554,738	35	497,592		33,173	29,756	8
9	25	TRANSPORTATION	INPATIENT DAYS	554,738	35			33,173		9
10	26	INSURANCE	INPATIENT DAYS	554,738	35	60,487		33,173	3,618	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	554,738	35	832,136		33,173	49,761	11
12	32	INTEREST	INPATIENT DAYS	554,738	35	114,803		33,173	6,865	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	554,738	35	30,606		33,173	1,830	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	554,738	35	37,880		33,173	2,265	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		\$ 388,964		25

Facility Name & ID Number University Nsg & Rehab Ctr

0046557

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						\$ 206,125	1
2	39	OCCUPATIONAL THERAPY						215,069	2
3	39	SPEECH THERAPY						50,343	3
4	39	THERAPY MGT FEES						36,339	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				\$	\$		\$ 507,876	25

Facility Name & ID Number

University Nsg & Rehab Ctr

0046557

Report Period Beginning:

1/1/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	OMNICARE		X	NOTE PAYABLE				6,292								
7																
8																
9	TOTAL Facility Related						\$	\$ 6,292			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$ 6,292			\$					

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.		\$	<u>75,525</u>	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.)		\$	<u>74,952</u>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(573)</u>	3															
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>74,846</u>	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.		\$	<u>74,273</u>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>72,851</u>	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> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>74,273</u>	9																
	2011	<u>73,416</u>	10																
	2012	<u>73,878</u>	11																
	2013	<u>74,952</u>	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 University Nsg & Rehab Ctr COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0046557

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>14-2-15-15-11-201-002.001</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>74,951.80</u>	\$ <u>74,951.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>74,951.80</u></u>	\$ <u><u>74,951.80</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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,290 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).

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

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	14,688		20	734	734	8,077	9
10	VARIOUS		2005	12,622		20	631	631	6,312	10
11	VARIOUS		2006	19,362		20	968	968	11,118	11
12	VARIOUS		2007	22,531		20	1,127	1,127	7,690	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 carpet	2008	\$ 2,000	\$	20	\$ 100	\$ 100	\$ 700	37
38	Wall Posts	2008	2,798		20	140	140	980	38
39	Wiring in Kitchen	2008	1,835		20	92	92	643	39
40	Fire Alarm	2008	2,814		20	141	141	986	40
41	Sidewalks, Metal Roof	2008	5,482		20	274	274	1,918	41
42	Water Heater	2008	2,343		20	117	117	820	42
43	New Tile & Carpet	2008	3,097		20	155	155	1,084	43
44	Seal Coat Asphalt	2008	5,035		20	252	252	1,763	44
45	Drapery	2008	1,184		20	59	59	414	45
46	Drapery	2008	1,099		20	55	55	385	46
47	Carpet	2008	1,348		20	67	67	471	47
48	Generator	2009	43,247		20	2,162	2,162	12,973	48
49	New Sidewalk	2009	3,327		20	166	166	997	49
50	Water Heater	2009	5,800		20	290	290	1,740	50
51	Kitchen Wall	2010	13,830		20	692	692	3,459	51
52	Propane Tank/Pipe	2010	3,775		20	189	189	945	52
53	Shower Floors & Walls	2011	6,887		20	344	344	1,376	53
54	Tub, Shower, Bathroom Tile	2011	7,747		20	387	387	1,548	54
55	Tall chain Link Fence with Pds Slats	2011	4,415		20	221	221	884	55
56	Flooring installed in the living room area of the dining room	2012	11,825		20	296	296	888	56
57	Roof Replacement Wing A	2013	20,735		10	2,074	2,074	2,765	57
58	Water Heater - 119 Gallon	2014	7,820		10	130	130	130	58
59				13,228			(13,228)		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)		\$ 227,646	\$ 13,228		\$ 11,863	\$ (1,365)	\$ 71,066	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	\$ 100,098	\$ 9,557	\$ 10,010	\$ 453		\$ 37,853	71
72	Current Year Purchases	937	141	141			141	72
73	Fully Depreciated Assets	56,461					56,461	73
74								74
75	TOTALS	\$ 157,496	\$ 9,698	\$ 10,151	\$ 453		\$ 94,455	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)	\$ 385,142	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,926	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,014	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (912)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 165,521	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>122</u>		\$ <u>238,424</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		122		\$ 238,424			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: \$ 19,542 Description: SEE ATTACHED SCHEDULE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number University Nsg & Rehab Ctr # 0046557 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?</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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	39-03	hrs	\$	4,624	\$ 221,939				4,624	\$ 221,939					1
2	Licensed Speech and Language Development Therapist	39-03	hrs		1,019	51,951				1,019	51,951					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-03	hrs		3,939	212,710				3,939	212,710					4
5	Physician Care		visits			1,970					1,970					5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-02	# of prescripts							143,998	143,998					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Ambulance, Therapy Fees</u>							47,374			47,374					12
13	Other (specify): <u>Lab & X-ray</u>	43-03						13,918			13,918					13
14	TOTAL			\$	9,582	\$ 549,862			\$ 143,998	9,582	\$ 693,860					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 University Nsg & Rehab Ctr

0046557

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	\$ 142,433	\$	1
2	Cash-Patient Deposits	15,862		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	981,055		3
4	Supply Inventory (priced at)	11,026		4
5	Short-Term Investments			5
6	Prepaid Insurance	55,159		6
7	Other Prepaid Expenses	35		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Asset Clearing</u>	37,954		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,243,524	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	201,487		15
16	Equipment, at Historical Cost	157,496		16
17	Accumulated Depreciation (book methods)	(184,327)		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)	\$ 174,656	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,418,180	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,082,612	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(8,313)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,574		32
33	Accrued Interest Payable	91,870		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	(2,388)		36
37	<u>Resident Trust Fund Liability</u>	15,862		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,255,217	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	6,292		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)	\$ 6,292	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,261,509	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 156,671	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,418,180	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 89,776	1
2	Restatements (describe):		2
3			3
4	CHANGE IN ACCUMULATED SURPLUS	(111,310)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (21,534)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	178,196	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	9	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 178,205	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)	\$ 156,671	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	\$ 6,014,510	1
2	Discounts and Allowances for all Levels	(1,334,900)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,679,610	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	917,426	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 917,426	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	91,045	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,968	19
20	Radiology and X-Ray	3,393	20
21	Other Medical Services	22,500	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 122,906	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,737	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,737	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	247	28
28a	UNIFORM INCOME	3,057	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,304	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,725,983	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	899,109	31
32	Health Care	2,145,377	32
33	General Administration	1,080,333	33
B. Capital Expense			
34	Ownership	430,554	34
C. Ancillary Expense			
35	Special Cost Centers	693,860	35
36	Provider Participation Fee	298,554	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,547,787	40
41	Income before Income Taxes (line 30 minus line 40)**	178,196	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 178,196	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,995,390	44
45	Private Pay - Net Inpatient Revenue	1,413,415	45
46	Medicare - Net Inpatient Revenue	413,129	46
47	Other-(specify)		47
48	Other-(specify) Part B, Bad Debts, Prior Year Income	(142,324)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,679,610	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 University Nsg & Rehab Ctr

0046557

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	1,952	2,160	\$ 80,098	\$ 37.08	1
2	Assistant Director of Nursing	1,812	1,924	54,222	28.18	2
3	Registered Nurses	7,561	8,456	209,170	24.74	3
4	Licensed Practical Nurses	21,655	23,950	532,396	22.23	4
5	CNAs & Orderlies	64,232	69,548	891,756	12.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,495	6,113	48,259	7.89	10
11	Social Service Workers	4,741	5,283	95,989	18.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,973	17,912	194,874	10.88	15
16	Dishwashers					16
17	Maintenance Workers	2,924	3,244	47,584	14.67	17
18	Housekeepers	4,597	5,011	57,136	11.40	18
19	Laundry	8,768	9,655	100,287	10.39	19
20	Administrator	2,128	2,376	99,375	41.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,876	4,179	111,797	26.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,718	2,066	24,860	12.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,432	161,877	\$ 2,547,803 *	\$ 15.74	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	169	\$ 8,430	1.3	35
36	Medical Director	Monthly	39,000	9.3	36
37	Medical Records Consultant	24	1,609	10.3	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	18	1,466	11.3	44
45	Social Service Consultant	18	816	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	229	\$ 51,321		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	
Rebecca Garcia	ADMINISTRATOR		\$ 62,740	Workers' Compensation Insurance	\$ 76,541	IDPH License Fee	\$		
Barbara Lowry	ADMINISTRATOR		14,308	Unemployment Compensation Insurance		Advertising: Employee Recruitment		14,941	
Elizabeth Stotser	ADMINISTRATOR		22,327	FICA Taxes	262,539	Health Care Worker Background Check		1,185	
				Employee Health Insurance	154,477	(Indicate # of checks performed <u>40</u>)			
				Employee Meals		Patient Background Checks	<u>103</u>	1,648	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Donations		20,072	
				Other Employee Benefits	18,820	Dues & Subscriptions		436	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,375			Licenses & Fees		855	
B. Administrative - Other						Allocation from Ide Management		1,840	
Description			Amount			Less: Public Relations Expense	(
Management Fees - Ide Management Group			\$ 25,000			Non-allowable advertising		(20,072)	
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 25,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 512,377	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,905
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			\$ 174,260				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	4,201	
							Allocation from Ide Management	29,756	
							Entertainment Expense	(485)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 174,260	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 33,472

* 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 University Nsg & Rehab Ctr

0046557

Report Period Beginning:

1/1/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,298 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. \$ 298,554
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.