

Facility Name & ID Number North Logan Healthcare Ctr

0046532 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,708	5,726	4,364	29,798	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,708	5,726	4,364	29,798	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.59%

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 108 and days of care provided 4,364

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number

North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	232,944	12,879	3,186	249,009		249,009		249,009		1
2	Food Purchase		190,923		190,923		190,923	(388)	190,535		2
3	Housekeeping	107,650	32,033		139,683		139,683		139,683		3
4	Laundry	53,859	19,002		72,861		72,861		72,861		4
5	Heat and Other Utilities			140,717	140,717		140,717		140,717		5
6	Maintenance	62,648	22,880	57,191	142,719		142,719	51	142,770		6
7	Other (specify):*										7
8	TOTAL General Services	457,101	277,717	201,094	935,912		935,912	(337)	935,575		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,687,377	174,821	8,582	1,870,780		1,870,780		1,870,780		10
10a	Therapy		7,523	5,411	12,934		12,934		12,934		10a
11	Activities	59,283	3,426	1,620	64,329		64,329		64,329		11
12	Social Services	37,831		1,153	38,984		38,984		38,984		12
13	CNA Training										13
14	Program Transportation			500	500		500		500		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,784,491	185,770	41,266	2,011,527		2,011,527		2,011,527		16
	C. General Administration										
17	Administrative	84,914		120,000	204,914		204,914	(44,066)	160,848		17
18	Directors Fees										18
19	Professional Services			129,037	129,037		129,037	(103)	128,934		19
20	Dues, Fees, Subscriptions & Promotions			26,526	26,526		26,526	(9,092)	17,434		20
21	Clerical & General Office Expenses	134,588	32,769	39,348	206,705		206,705	105,940	312,645		21
22	Employee Benefits & Payroll Taxes			508,571	508,571		508,571	(356)	508,215		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,352	6,352		6,352	40,240	46,592		24
25	Other Admin. Staff Transportation			22,348	22,348		22,348	(1,594)	20,754		25
26	Insurance-Prop.Liab.Malpractice			138,726	138,726		138,726	215	138,941		26
27	Other (specify):*							57,869	57,869		27
28	TOTAL General Administration	219,502	32,769	990,908	1,243,179		1,243,179	149,053	1,392,232		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,461,094	496,256	1,233,268	4,190,618		4,190,618	148,716	4,339,334		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			56,440	56,440	56,440	29,974	86,414				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						(2,201)	(2,201)				32
33	Real Estate Taxes			86,904	86,904	86,904		86,904				33
34	Rent-Facility & Grounds			240,000	240,000	240,000	88,669	328,669				34
35	Rent-Equipment & Vehicles			51,478	51,478	51,478	1,892	53,370				35
36	Other (specify):*											36
37	TOTAL Ownership			434,822	434,822	434,822	118,334	553,156				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,971	683,343	904,314	904,314	(10,829)	893,485				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,175	194,175	194,175		194,175				42
43	Other (specify):* LAB & X-RAY			20,178	20,178	20,178		20,178				43
44	TOTAL Special Cost Centers		220,971	897,696	1,118,667	1,118,667	(10,829)	1,107,838				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,461,094	717,227	2,565,786	5,744,107	5,744,107	256,221	6,000,328				45

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

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning: 1/1/15

Ending: 12/31/15

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	(206)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,674)	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	29,974	30		9
10	Interest and Other Investment Income	(4,282)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(182)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(245)	21		18
19	Entertainment	(474)	24		19
20	Contributions	1,206	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,106)	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	48,903			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 56,914		\$	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)	199,307		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 199,307		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 256,221		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

North Logan Healthcare Ctr

ID# 0046532

Report Period Beginning: 1/1/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	BANK CHARGES	\$ (4,553)	21	1
2	MARKETING TRAVEL	(1,594)	25	2
3	MARKETING SALARY	(1,724)	21	3
4	MARKETING EB	(356)	22	4
5	ADJUST LEASE EXPENSE TO ACTUAL	87,436	34	5
6	MISCELLANEOUS INCOME	(2,666)	21	6
7	VENDING MACHINE	(953)	21	7
8	NON-ALLOWABLE LEGAL FEES	(14,725)	19	8
9	MARKETING SUPPLIES	(11,629)	21	9
10				10
11				11
12	MISC. EXP-PY ADJUSTMENTS	(333)	21	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		48,903	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Logan Healthcare Ctr# 0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	(388)	0	0	0	0	0	0	0	0	0	0	(388)	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	51	0	0	0	0	0	0	0	0	51	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(388)	0	51	0	(337)	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	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(44,066)	0	0	0	0	0	0	0	0	(44,066)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,725)	0	14,622	0	0	0	0	0	0	0	0	(103)	19
20	Fees, Subscriptions & Promotions	(9,106)	0	14	0	0	0	0	0	0	0	0	(9,092)	20
21	Clerical & General Office Expenses	(29,571)	0	135,511	0	0	0	0	0	0	0	0	105,940	21
22	Employee Benefits & Payroll Taxes	(356)	0	0	0	0	0	0	0	0	0	0	(356)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(474)	0	40,714	0	0	0	0	0	0	0	0	40,240	24
25	Other Admin. Staff Transportation	(1,594)	0	0	0	0	0	0	0	0	0	0	(1,594)	25
26	Insurance-Prop.Liab.Malpractice	0	0	215	0	0	0	0	0	0	0	0	215	26
27	Other (specify):*	0	0	57,869	0	0	0	0	0	0	0	0	57,869	27
28	TOTAL General Administration	(55,826)	0	204,879	0	149,053	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(56,214)	0	204,930	0	148,716	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	29,974	0	0	0	0	0	0	0	0	0	0	29,974	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,282)	0	2,081	0	0	0	0	0	0	0	0	(2,201)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	87,436	0	1,233	0	0	0	0	0	0	0	0	88,669	34
35	Rent-Equipment & Vehicles	0	0	1,892	0	0	0	0	0	0	0	0	1,892	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	113,128	0	5,206	0	118,334	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	(10,829)	0	0	0	0	0	0	0	0	0	(10,829)	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	(10,829)	0	0	0	0	0	0	0	0	0	(10,829)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	56,914	(10,829)	210,136	0	0	0	0	0	0	0	0	256,221	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	\$ 305,656	Tru Rehab, LLC	100.00%	\$ 300,766	\$ (4,890)	1
2	V	39 Occupational Therapy	308,120	Tru Rehab, LLC	100.00%	303,190	(4,930)	2
3	V	39 Speech Therapy	28,574	Tru Rehab, LLC	100.00%	28,117	(457)	3
4	V	39 Therapy Management Fee	34,500	Tru Rehab, LLC	100.00%	33,948	(552)	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		\$ 676,850			\$ 666,021	\$ * (10,829)	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%	51	51	16
17	V	10 NURSING		IDE MANAGEMENT GROUP, LLC	100.00%			17
18	V	17 ADMINISTRATIVE		IDE MANAGEMENT GROUP, LLC	100.00%	75,934	75,934	18
19	V	19 PROFESSIONAL FEES		IDE MANAGEMENT GROUP, LLC	100.00%	14,622	14,622	19
20	V	20 DUES, FEES, SUB		IDE MANAGEMENT GROUP, LLC	100.00%	14	14	20
21	V	21 CLERICAL & GENERAL		IDE MANAGEMENT GROUP, LLC	100.00%	135,511	135,511	21
22	V	24 TRAVEL & SEMINAR		IDE MANAGEMENT GROUP, LLC	100.00%	40,714	40,714	22
23	V	25 TRANSPORTATION		IDE MANAGEMENT GROUP, LLC	100.00%			23
24	V	26 INSURANCE		IDE MANAGEMENT GROUP, LLC	100.00%	215	215	24
25	V	27 EMPLOYEE BENEFITS		IDE MANAGEMENT GROUP, LLC	100.00%	57,869	57,869	25
26	V	32 INTEREST		IDE MANAGEMENT GROUP, LLC	100.00%	2,081	2,081	26
27	V	34 RENT-FACILITY & GROUNDS		IDE MANAGEMENT GROUP, LLC	100.00%	1,233	1,233	27
28	V	35 RENT-EQUIP & VEH		IDE MANAGEMENT GROUP, LLC	100.00%	1,892	1,892	28
29	V							29
30	V	17 MANAGEMENT FEES	120,000	IDE MANAGEMENT GROUP, LLC	100.00%		(120,000)	30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 120,000			\$ 330,136	\$ * 210,136	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* 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		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* 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		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

Facility Name & ID Number

North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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%	CATHEDRAL HEALTH CARE CENTER	JASPER, IN	IDE MANAGEMENT	INDIANAPOLIS, IN	BOOKKEEPING/M	1
2			CHESTERTON MANOR	CHESTERTON, IN	TRU REHAB, LLC	VINCENNES, IN	THERAPY-REHAB	2
3			CLOVERLEAF OF KNIGHTSVILLE	KNIGHTSVILLE, IN	DAVIS IHC PROP	INDIANAPOLIS, IN	PROPERTY MGT	3
4			COLONIAL HEALTH CARE	CROWN POINT, IN				4
5			KENDALLVILLE MANOR	KENDALLVILLE, IN				5
6			MADISON HEALTH CARE CENTER	INDIANAPOLIS, IN				6
7			OAK VILLAGE HEALTH CARE	OAKTOWN, IN				7
8			SILVER MEMORIES	VERSAILLES, IN				8
9			WARSAW MEADOWS	WARSAW, IN				9
10			WOODLAND MANOR	ELKHART, IN				10
11			WOODLANDS AT RIVER TERRACE	BLUFFTON, IN				11
12			YORKTOWN MANOR	YORKTOWN, IN				12
13			EDWARDSVILLE NSG & REHAB CTR	EDWARDSVILLE, IL				13
14			UNIVERSITY NSG & REHAB CTR	EDWARDSVILLE, IL				14
15			PARIS HEALTHCARE CENTER	PARIS, IL				15
16			NEWTON HEALTH CARE CENTER	NEWTON, IA				16
17			URBANDALE HEALTH CARE CENTER	URBANDALE, IA				17
18			KEOTA HEALTH CARE CENTER	KEOTA, IA				18
19			SIGOURNEY HEALTH CARE	SIGOURNEY, IA				19
20			KEOSAUQUA HEALTHCARE	KEOSAUQUA, IA				20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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								1
2								2
3								3
4								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	2.84	7.10	Alloc Salary	\$ 53,251	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	\$ 53,251		13

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

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

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 7465 MADISON AVENUE
 City / State / Zip Code INDIANAPOLIS, IN 46227
 Phone Number (317) 672-3363
 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	419,462	21	\$	\$	29,798	\$ 0	1
2	6	MAINTENANCE	INPATIENT DAYS	419,462	21	715		29,798	51	2
3	10	NURSING	INPATIENT DAYS	419,462	21			29,798	0	3
4	17	ADMINISTRATIVE	INPATIENT DAYS	419,462	21	1,068,890	1,068,890	29,798	75,934	4
5	19	PROFESSIONAL FEES	INPATIENT DAYS	419,462	21	205,827		29,798	14,622	5
6	20	DUES, FEES, SUB	INPATIENT DAYS	419,462	21	198		29,798	14	6
7	21	CLERICAL & GENERAL	INPATIENT DAYS	419,462	21	1,907,539	1,541,203	29,798	135,511	7
8	24	TRAVEL & SEMINAR	INPATIENT DAYS	419,462	21	573,116		29,798	40,714	8
9	25	TRANSPORTATION	INPATIENT DAYS	419,462	21			29,798	0	9
10	26	INSURANCE	INPATIENT DAYS	419,462	21	3,026		29,798	215	10
11	27	EMPLOYEE BENEFITS	INPATIENT DAYS	419,462	21	814,600		29,798	57,869	11
12	32	INTEREST	INPATIENT DAYS	419,462	21	29,299		29,798	2,081	12
13	34	RENT-FACILITY & GROUNDS	INPATIENT DAYS	419,462	21	17,359		29,798	1,233	13
14	35	RENT-EQUIP & VEH	INPATIENT DAYS	419,462	21	26,639		29,798	1,892	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,647,208	\$ 2,610,093		\$ 330,136	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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						\$ 300,766	1
2	39	OCCUPATIONAL THERAPY						303,190	2
3	39	SPEECH THERAPY						28,117	3
4	39	THERAPY MGT FEES						33,948	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				\$	\$		\$ 666,021	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending: 12/31/15

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									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				\$	\$		\$	25

Facility Name & ID Number

North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	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 2014 report.		\$	<u>88,602</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>88,486</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(116)</u>	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>87,021</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>86,905</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>105,756</u>	8		
	2011	<u>102,860</u>	9		
	2012	<u>97,947</u>	10		
	2013	<u>88,603</u>	11		
	2014	<u>88,486</u>	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Logan Healthcare Ctr COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0046532

CONTACT PERSON REGARDING THIS REPORT CLAUDETTE PICKENS

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 2014 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 2014.

(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>23-06-411-006-0060</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>86,787.88</u>	\$ <u>86,787.88</u>
2. <u>23-06-411-011-0060</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>848.90</u>	\$ <u>848.90</u>
3. <u>23-06-411-012-0060</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>848.90</u>	\$ <u>848.90</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>88,485.68</u></u>	\$ <u><u>88,485.68</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Logan Healthcare Ctr COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0046532

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number North Logan Healthcare Ctr

0046532 Report Period Beginning:

1/1/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		2004	13,863		20	693	693	8,657
10	Various		2005	29,957		20	1,498	1,498	17,142
11	Various		2006	8,930		20	447	447	4,467
12	Various		2007	610		20	31	31	559
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	Carpeting	2008	\$ 530	\$	20	\$ 27	\$ 27	\$ 214	37
38	New Secure Care Key Pad	2008	1,657		20	83	83	663	38
39	Wallpapering	2008	1,036		20	52	52	415	39
40	Wallpapering	2008	1,455		20	73	73	583	40
41	Install Remote Generator Annunciator Panel	2008	3,641		20	182	182	1,456	41
42	P&G Pump Housing Repair and Upgrade	2008	3,145		20	157	157	1,256	42
43	Holby Mixing Valve - Boiler Repair	2009	3,114		20	156	156	1,091	43
44	Room Renovations - Paintwork	2009	3,698		20	185	185	1,295	44
45	Heater Booster	2010	2,915		20	146	146	875	45
46	Awning	2011	3,385		20	169	169	845	46
47	Fire Alarm System	2011	9,335		20	467	467	2,335	47
48	Fire Alarm Inspection	2011	3,041		20	152	152	760	48
49	Two Shunt Trip Breakers	2011	2,950		20	148	148	740	49
50	Generator Starter Replaced	2011	3,581		20	179	179	895	50
51	Main Sign Relocation	2013	4,970		10	497	497	1,160	51
52	Plumbing Installed Backflows on Pipes	2013	5,378		25	215	215	448	52
53	1st Floor Dining Room, Conference Room,	2013	67,452		15	4,497	4,497	9,369	53
54	and Hallway Renovation Consisting of Wall Repair, Wall								54
55	and Ceiling Paint, Carpet and Vinyl Plank Flooring								55
56	Installation, and Door and Base Trim and 1st Floor Visitor								56
57	Bathroom Renovation Consisting of Grab Bars, Mirror,								57
58	Outlets, and Switch Replacement								58
59	Landscaping	2014	21,850		10	2,185	2,185	3,824	59
60	Booster Heater C15 208V, 3PH (HATCO)	2014	2,235		10	224	224	392	60
61	New carpet	2014	4,450		5	890	890	1,558	61
62	Water Heater and tempering valve replaced	2014	11,230		10	1,123	1,123	1,965	62
63	Circulator pumps for boiler	2014	3,950		10	395	395	461	63
64	Install door restrictions on elevator	2014	5,460		15	364	364	425	64
65	New contactor for air conditioner	2014	4,236		10	424	424	495	65
66	New condenser for air conditioner	2014	4,677		15	312	312	364	66
67	Duct work	2014	1,172		20	59	59	69	67
68	Air conditioner work	2014	5,924		7	846	846	987	68
69	Installed two new valves on boiler and water heater	2014	3,474		10	347	347	405	69
70	TOTAL (lines 4 thru 69)		\$ 243,301	\$		\$ 17,223	\$ 17,223	\$ 66,170	70

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

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 243,301	\$		\$ 17,223	\$ 17,223	\$ 66,170	1
2	Curtain rods and drapes	2014	10,216		10	1,022	1,022	1,192	2
3	Premium Faux wood blinds	2014	8,842		10	884	884	1,031	3
4	Curtain rods and drapes	2014	2,009		10	201	201	234	4
5	New signs throughout building (stairwell,restroom, common room, etc.)	2014	5,919		15	395	395	461	5
6									6
7	Flooring - Armstrong -ceramic tile in bathrooms	2015	1,564		20	46	46	46	7
8	120 Capacity Pellet Heater	2015	5,035		20	84	84	84	8
9	20 Amp Industrial Pole Switch	2015	529		20	24	24	24	9
10	Secure Care Door Access Control	2015	15,797		20	790	790	790	10
11	Floor Care 14 Rooms	2015	2,279		20	86	86	86	11
12	Awning	2015	5,482		20	274	274	274	12
13	Exterior Doors	2015	27,500		20	229	229	229	13
14	Flooring - vinyl plank flooring throught facility	2015	93,640		10	1,561	1,561	1,561	14
15	Key Pad - Delayed Egress Controller	2015	3,558		20	89	89	89	15
16	Circuit /Outlet for New Kiosks	2015	1,846		20	23	23	23	16
17	Total renovation of facility incl: remodel of all resident rms, addition of 2 therapy gyms & therapy room	2015	1,052,314		20	9,163	9,163	9,163	17
18									18
19				29,876			(29,876)		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	34

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

Facility Name & ID Number North Logan Healthcare Ctr

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		
1	Totals from Page 12B, Carried Forward	\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456		34

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

Facility Name & ID Number North Logan Healthcare Ctr

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		
1	Totals from Page 12C, Carried Forward	\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456		34

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

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	
1	Totals from Page 12D, Carried Forward		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	34

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

Facility Name & ID Number North Logan Healthcare Ctr

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	1
2									2
3									3
4									4
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	34

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

Facility Name & ID Number North Logan Healthcare Ctr

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		
1	Totals from Page 12F, Carried Forward	\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456		1
2									2
3									3
4									4
5									5
6									6
7									7
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456		34

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

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	
1	Totals from Page 12G, Carried Forward		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	34

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

Facility Name & ID Number North Logan Healthcare Ctr

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,479,830	\$ 29,876		\$ 32,093	\$ 2,217	\$ 81,456	34

**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	\$ 155,881	\$ 10,338	\$ 15,588	\$ 5,250	10	\$ 88,789	71
72	Current Year Purchases	289,211	7,831	28,321	20,490	7	28,321	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 445,092	\$ 18,169	\$ 43,909	\$ 25,740		\$ 117,110	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 FORD VAN	2010	\$ 4,500	\$	\$	\$	5	\$ 4,500	76
77		2011 FORD E350	2015	41,650	8,395	10,413	2,018	4	10,413	77
78										78
79										79
80	TOTALS			\$ 46,150	\$ 8,395	\$ 10,413	\$ 2,018		\$ 14,913	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)	\$ 1,971,072	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,440	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,414	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,974	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 213,478	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:		108		\$ 327,436			3
4	Additions							4
5								5
6								6
7	TOTAL		108		\$ 327,436			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 51,478 Description: SEE ATTACHED SCHEDULE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr # 0046532 Report Period Beginning: 1/1/15 Ending: 12/31/15
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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$	4,402	\$ 308,120	\$	4,402	\$ 308,120	1
2	Licensed Speech and Language Development Therapist	39-03	hrs		409	28,574		409	28,574	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs		4,367	305,656		4,367	305,656	4
5	Physician Care	39-03	visits			366			366	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				220,971		220,971	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	39-03					6,127		6,127	12
13	Other (specify): <u>Lab & x-ray</u>	43-03					20,178		20,178	13
14	TOTAL			\$	9,178	\$ 642,716	\$ 247,276	9,178	\$ 889,992	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 North Logan Healthcare Ctr

0046532

Report Period Beginning: 1/1/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 90,288	\$	1
2	Cash-Patient Deposits	28,981		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	890,802		3
4	Supply Inventory (priced at)	10,695		4
5	Short-Term Investments			5
6	Prepaid Insurance	(1,112)		6
7	Other Prepaid Expenses	2,417		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): CAPITAL RESERVE	6,039		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,028,110	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,361,137		14
15	Leasehold Improvements, at Historical Cost	79,794		15
16	Equipment, at Historical Cost	491,241		16
17	Accumulated Depreciation (book methods)	(199,580)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,732,592	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,760,702	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,915,982	\$	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)	87,021		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	ACCRUED BED TAX	(13,797)		36
37	RESIDENT TRUST FUND LIAB/DTDF I	1,208,949		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,198,155	\$	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)	\$ 3,198,155	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (437,453)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,760,702	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (211,151)	1
2	Restatements (describe):		2
3			3
4	CHANGE IN ACCUM SURPLUS	(15,869)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (227,020)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(210,433)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (210,433)	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)	\$ (437,453)	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	\$ 3,863,412	1
2	Discounts and Allowances for all Levels	233,680	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,097,092	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,218,112	6
7	Oxygen	19,608	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,237,720	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	206	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	175,565	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,000	19
20	Radiology and X-Ray	8,190	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 190,961	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,282	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,282	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING/OTHER INCOME	3,619	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,619	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,533,674	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	935,912	31
32	Health Care	2,011,527	32
33	General Administration	1,243,179	33
B. Capital Expense			
34	Ownership	434,822	34
C. Ancillary Expense			
35	Special Cost Centers	924,492	35
36	Provider Participation Fee	194,175	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,744,107	40
41	Income before Income Taxes (line 30 minus line 40)**	(210,433)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (210,433)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,431,858	44
45	Private Pay - Net Inpatient Revenue	851,355	45
46	Medicare - Net Inpatient Revenue	1,690,479	46
47	Other-(specify) <u>MGC INS</u>	245,978	47
48	Other-(specify) <u>Part B, Bad Debts, Prior Year, Other Ancillary</u>	(1,122,578)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,097,092	49

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

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

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

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

Facility Name & ID Number North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	2,055	2,096	\$ 79,092	\$ 37.73	1
2	Assistant Director of Nursing	1,992	2,133	60,149	28.20	2
3	Registered Nurses	17,950	19,355	496,970	25.68	3
4	Licensed Practical Nurses	15,742	17,055	340,260	19.95	4
5	CNAs & Orderlies	59,595	62,981	670,034	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,268	4,625	59,283	12.82	10
11	Social Service Workers	2,406	2,538	37,831	14.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,892	22,216	232,944	10.49	15
16	Dishwashers					16
17	Maintenance Workers	3,883	4,152	62,648	15.09	17
18	Housekeepers	10,529	11,116	107,650	9.68	18
19	Laundry	5,551	6,061	53,859	8.89	19
20	Administrator	1,819	1,979	84,914	42.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,736	4,060	134,588	33.15	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	1,981	2,248	40,872	18.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,399	162,615	\$ 2,461,094 *	\$ 15.13	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	64	\$ 3,186	1.2	35
36	Medical Director	MONTHLY	24,000	9.3	36
37	Medical Records Consultant	65	3,104	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	4,581	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	696	11.3	44
45	Social Service Consultant	19	1,153	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	160	\$ 36,720		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-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 North Logan Healthcare Ctr

0046532

Report Period Beginning:

1/1/15

Ending:

12/31/15

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? 5-7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,687 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 194,175
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%
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.