



Facility Name & ID Number The H & J Vonderlieth Lvg Ctr

# 0019976 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1	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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	11,513	11,978	2,007	25,498	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,513	11,978	2,007	25,498	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.62%

D. How many bed-hold days during this year were paid by the Department? 0 (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 1970

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 2,007

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name &amp; ID Number

The H &amp; J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	202,495	22,199		224,694		224,694	224,694			1
2	Food Purchase		181,174		181,174		181,174	181,174			2
3	Housekeeping	88,967	34,179		123,146		123,146	123,146			3
4	Laundry	54,348	14,333		68,681		68,681	68,681			4
5	Heat and Other Utilities			83,047	83,047		83,047	83,047			5
6	Maintenance	80,750	70,925	78,861	230,536		230,536	230,536			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>426,560</b>	<b>322,810</b>	<b>161,908</b>	<b>911,278</b>		<b>911,278</b>	<b>911,278</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	1,559,712	92,727	5,994	1,658,433		1,658,433	1,658,433			10
10a	Therapy		70,908	320,774	391,682	(96,682)	295,000	295,000			10a
11	Activities	49,964	5,166		55,130		55,130	55,130			11
12	Social Services	40,688	18	4,943	45,649		45,649	45,649			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,650,364</b>	<b>168,819</b>	<b>343,711</b>	<b>2,162,894</b>	<b>(96,682)</b>	<b>2,066,212</b>	<b>2,066,212</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	62,037			62,037		62,037	62,037			17
18	Directors Fees										18
19	Professional Services			211,079	211,079		211,079	(1,291)	209,788		19
20	Dues, Fees, Subscriptions & Promotions			94,737	94,737	(49,275)	45,462	(40,195)	5,267		20
21	Clerical & General Office Expenses	259,693	22,410	10,563	292,666		292,666	292,666			21
22	Employee Benefits & Payroll Taxes			514,459	514,459		514,459	514,459			22
23	Inservice Training & Education			9,072	9,072		9,072	9,072			23
24	Travel and Seminar			3,099	3,099		3,099	(1,100)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			124,401	124,401		124,401	124,401			26
27	Other (specify):*			325	325		325	325			27
28	<b>TOTAL General Administration</b>	<b>321,730</b>	<b>22,410</b>	<b>967,735</b>	<b>1,311,875</b>	<b>(49,275)</b>	<b>1,262,600</b>	<b>(42,586)</b>	<b>1,220,014</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,398,654</b>	<b>514,039</b>	<b>1,473,354</b>	<b>4,386,047</b>	<b>(145,957)</b>	<b>4,240,090</b>	<b>(42,586)</b>	<b>4,197,504</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

The H &amp; J Vonderlieth Lvg Ctr

#0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			151,128	151,128		151,128		151,128			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(19,100)	(19,100)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,986	11,986		11,986		11,986			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			163,114	163,114		163,114	(19,100)	144,014			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						96,682		96,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						49,275		49,275			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>						145,957		145,957			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,398,654	514,039	1,636,468	4,549,161		4,549,161	(61,686)	4,487,475			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 The H & J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning: 01/01/13

Ending: 12/31/13

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,100)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(125)			17
18	Fines and Penalties				18
19	Entertainment	(1,100)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,291)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(40,070)			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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (61,686)</b>		<b>\$</b>	<b>30</b>

**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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (61,686)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

The H & J Vonderlieth Lvg Ctr

ID# 0019976

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		0	33	15
16			24	16
17		(125)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,291)	19	22
23				23
24		0	27	24
25		(40,070)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(41,486)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number The H & J Vonderlieth Lvg Ctr# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,291)	0	0	0	0	0	0	0	0	0	0	(1,291)	19
20	Fees, Subscriptions & Promotions	(40,195)	0	0	0	0	0	0	0	0	0	0	(40,195)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(42,586)	0	0	0	0	0	0	0	0	0	0	(42,586)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(42,586)	0	0	0	0	0	0	0	0	0	0	(42,586)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number The H & J Vonderlieth Lvg Ctr# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,100)	0	0	0	0	0	0	0	0	0	0	(19,100)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(19,100)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(19,100)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(61,686)	0	0	0	0	0	0	0	0	0	0	(61,686)	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

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		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number

The H & J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 The H & J Vonderlieth Lvg Ctr # 0019976 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Attached								\$	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	\$	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 The H & J Vonderlieth Lvg Ctr

# 0019976 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

The H & J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
	<b>Working Capital</b>															
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$					
	<b>B. Non-Facility Related*</b>															
10	<b>Interest Income</b>										(19,100)					
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(19,100)					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			(19,100)					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2012 report.		\$			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.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<b>FOR BHF USE ONLY</b>		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The H & J Vonderlieth Lvg Ctr COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0019976

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 2012 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 2012.

	(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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <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                 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number The H & J Vonderlieth Lvg Ctr

# 0019976 Report Period Beginning:

01/01/13 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,140 B. General Construction Type: Exterior brick Frame wood Number of Stories \_\_\_\_\_

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				\$ <u>55,924</u>	1
2					2
3	TOTALS			\$ <u>55,924</u>	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	90			\$ 1,172,276	\$		\$	\$	\$
5				441,636					
6									
7									
8									
<b>Improvement Type**</b>									
9	1979 Improvements		1979	11,345					
10	1981 Improvements		1981	1,209					
11	1982 Improvements		1982	1,175					
12	1984 Improvements		1984	6,809					
13	1985 Improvements		1985	14,582					
14	1986 Improvements		1986	44,534					
15	1987 Improvements		1987	29,649					
16	1990 Improvements		1990	985					
17	1991 Improvements		1991	155,036					
18	1992 Improvements		1992	26,901					
19	1988 Improvements		1988	437					
20	1983 Improvements		1983	954					
21	1993 Improvements		1993	10,736					
22	1994 Improvements		1994	5,683					
23	1995 Improvements		1995	335,750					
24	1996 Improvements		1996	9,161					
25	1997 Improvements		1997	1,691					
26	1998 Improvements		1998	837,524					
27	1999 Improvements		1999	1,020					
28	Lowered one head		2000	2,087					
29	8 steel doors		2000	437					
30	11 smoke dampers		2000	21,450					
31	card zone expander		2000	3,185					
32	floor tile		2000	6,290					
33									
34									
35	Book Depreciation				151,128		151,128		
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 &amp; ID Number The H &amp; J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	Shuffleboard court	2004	\$ 3,887	\$		\$	\$	\$	37
38	Seal coating	2004	2,507						38
39	Concrete street	2003	19,875						39
40									40
41	driveway filler	2002	6,489						41
42	boiler	2001	64,480						42
43	4' wall base	2001	19,200						43
44	12 locks	2002	23,618						44
45	boiler room door	2002	1,233						45
46	garage door	2002	71,872						46
47	sign	2003	1,967						47
48	fence	2003	6,800						48
49	compressor	2003	7,126						49
50	sidewalk	2004	10,150						50
51	asphalt	2004	648						51
52	Seal coating	2004	13,303						52
53	front door	2004	5,405						53
54	break box	2004	581						54
55	recepticals	2004	1,950						55
56	ceiling tile	2004	3,318						56
57	exit signs	2005	886						57
58	door and wall protective coverings	2005	3,993						58
59	tile south hall	2005	8,600						59
60	vinyl floor south rooms	2005	7,245						60
61	carpet living room	2005	9,300						61
62	gazebo roof	2005	3,312						62
63	kitchen air handler	2005	1,449						63
64	fan coil	2005	1,996						64
65	hvac units	2005	6,612						65
66	parking lot lights	2005	3,295						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,453,639	\$ 151,128		\$ 151,128	\$	\$	70

\*\*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 12A, Carried Forward		\$ 3,453,639	\$ 151,128		\$ 151,128	\$	\$	1
2									2
3	water chiller	2006	47,600						3
4	laundry room a/c	2006	1,848						4
5	sewage lift station	2006	14,645						5
6	reroof maint area	2007	4,149						6
7	mixing valve	2007	2,778						7
8	resident doors	2007	1,015						8
9	rear door	2007	3,401						9
10	door instillation	2007	995						10
11	blinds	2007	1,461						11
12	lower 1/2 wall covering	2007	14,302						12
13									13
14	resident room remodel--paint, floors	2008	16,035						14
15	parking lot	2008	6,000						15
16	air compressor	2008	3,000						16
17									17
18	Boiler	2009	3,956						18
19	Roof	2009	29,550						19
20	Asphalt Driveway	2009	43,852						20
21									21
22	Master Controller	2010	2,662						22
23	Blacktop sidewalks	2010	2,600						23
24	Roof	2010	18,980						24
25	Attic Fan	2010	4,729						25
26	Water Pipe	2010	2,510						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,679,707	\$ 151,128		\$ 151,128	\$	\$	34

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

Facility Name &amp; ID Number The H &amp; J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,679,707	\$ 151,128		\$ 151,128	\$	\$	1
2									2
3	Wireless Network	2011	24,302						3
4	Fire Alarm System	2011	42,585						4
5	Parking Lot	2011	102,806						5
6	Water Valve	2011	8,982						6
7	Oxygen Room Doors	2011	3,023						7
8	Driveway	2011	11,484						8
9	Oxygen Room Vent	2011	3,951						9
10	Handrails	2011	7,121						10
11	Lift station Pump	2011	7,937						11
12	Asphalt	2011	3,672						12
13									13
14	Show Room Remodel	2012	10,097						14
15	South Door & Installation	2012	13,424						15
16	Boiler	2012	4,900						16
17	Kitchen Exhaust	2012	35,144						17
18									18
19	Boiler Burner Replacement	2013	4,900						19
20	Canopy Sprinkler Head	2013	3,200						20
21	Roof Replacement	2013	77,730						21
22	Air Handlers & A/C Units	2013	22,030						22
23	Install Tile Floors - Bathroom	2013	4,170						23
24	Water Softener	2013	6,612						24
25	Hot Water Coil Replacement	2013	7,485						25
26	Garbage Disposal	2013	2,999						26
27	New Compressor for Chiller	2013	12,861						27
28	Painting & Cleaning - Fascia & Soffits	2013	5,380						28
29	AO Smith Water Heater	2013	27,586						29
30	Medicare Suites Conversion - Painting and Flooring	2013	20,396						30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,154,484	\$ 151,128		\$ 151,128	\$	\$	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	\$ 969,583	\$	\$	\$		\$	71
72	Current Year Purchases	15,322						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 984,905	\$	\$	\$		\$	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)	\$ 5,195,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,128	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,128	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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: \_\_\_\_\_

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:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 11,986 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

Facility Name & ID Number The H & J Vonderlieth Lvg Ctr # 0019976 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 124,766	\$		\$ 124,766	1
2	Licensed Speech and Language Development Therapist		hrs				46,880			46,880	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				123,235	119		123,354	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					70,789		70,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						25,893			25,893	13
14	<b>TOTAL</b>			\$			\$ 320,774	\$ 70,908		\$ 391,682	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 The H & J Vonderlieth Lvg Ctr# 0019976Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 144,602	\$	1
2	Cash-Patient Deposits	7,137		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	584,539		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,112		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	41,865		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 856,255	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	138,306		13
14	Buildings, at Historical Cost	3,934,346		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,106,333		16
17	Accumulated Depreciation (book methods)	(3,829,874)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,349,111	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,205,366	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 106,709	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,137		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,233		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Assessment Tax</u>	72,731		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 379,810	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 379,810	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,825,556	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,205,366	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,805,234	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,805,234	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	20,322	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)	\$ 20,322	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,825,556	24 *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,936,136	1
2	Discounts and Allowances for all Levels	(953,110)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,983,026</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,016,564	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,016,564</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	208	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	124,427	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,343	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 126,978</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	19,100	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 19,100</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		(185)	28
28a	<u>Funds from Trust</u>	424,000	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 423,815</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,569,483</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	911,278	31
32	Health Care	2,162,894	32
33	General Administration	1,311,875	33
<b>B. Capital Expense</b>			
34	Ownership	163,114	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,549,161</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>20,322</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 20,322</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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 The H & J Vonderlieth Lvg Ctr

# 0019976

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	1,971	2,133	\$ 75,647	\$ 35.47	1
2	Assistant Director of Nursing	1,987	2,117	69,504	32.83	2
3	Registered Nurses	6,225	6,507	193,049	29.67	3
4	Licensed Practical Nurses	21,418	23,415	529,889	22.63	4
5	CNAs & Orderlies	49,109	51,828	628,235	12.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,097	2,155	63,388	29.41	8
9	Activity Director					9
10	Activity Assistants	3,517	3,728	49,964	13.40	10
11	Social Service Workers	1,878	2,000	40,688	20.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,619	20,716	202,495	9.77	15
16	Dishwashers					16
17	Maintenance Workers	4,030	4,257	80,750	18.97	17
18	Housekeepers	9,124	9,677	88,967	9.19	18
19	Laundry	4,441	4,764	54,348	11.41	19
20	Administrator	1,900	2,080	62,037	29.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,685	13,552	259,693	19.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,001	148,929	\$ 2,398,654 *	\$ 16.11	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	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,420		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,189		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	4,943		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,552		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	50
51	Licensed Practical Nurses	0	0	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)		\$	53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Kynda Buenrostro</u>			\$ <u>62,037</u>	<u>Workers' Compensation Insurance</u>	\$ <u>107,017</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>903</u>	<u>Advertising: Employee Recruitment</u>	<u>2,745</u>	
				<u>FICA Taxes</u>	<u>183,497</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>217,383</u>	(Indicate # of checks performed _____)	<u>1,270</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>			<u>17,050</u>	
				<u>Other Benefits</u>	<u>5,659</u>	<u>Dues &amp; Subscriptions</u>	<u>498</u>	
						<u>License &amp; Fees</u>	<u>879</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>62,037</u>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		\$ <u>5,267</u>		
<b>(List each licensed administrator separately.)</b>						<b>Less: Public Relations Expense</b> <u>(17,050)</u>		
						<b>Non-allowable advertising</b> <u>(125)</u>		
						<b>Yellow page advertising</b> <u>( )</u>		
						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
						\$ <u>5,267</u>		
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>Description</b>			<b>Amount</b>	<b>Description</b>	<b>Line #</b>	<b>Amount</b>	<b>Description</b>	<b>Amount</b>
			\$			\$	<b>Out-of-State Travel</b>	\$
							<b>In-State Travel</b>	
								<u>2,760</u>
								<u>49</u>
							<b>Seminar Expense</b>	<u>290</u>
								<u>(1,100)</u>
							<b>Entertainment Expense</b>	<u>( )</u>
							(agree to Sch. V, line 24, col. 8)	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$	<b>TOTAL</b>		\$	<b>TOTAL</b>	\$ <u>1,999</u>
<b>(Attach a copy of any management service agreement)</b>								
<b>C. Professional Services</b>								
<b>Vendor/Payee</b>	<b>Type</b>		<b>Amount</b>					
<u>Heritage Operations Group</u>	<u>Mgt</u>		\$ <u>206,328</u>					
<u>BLDD Architects</u>	<u>Planning</u>		<u>1,342</u>					
<u>Steckel Parker</u>	<u>Architect</u>		<u>2,118</u>					
<u>Legal adj to Zero</u>			<u>1,291</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>211,079</u>					
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number The H & J Vonderlieth Lvg Ctr# 0019976Report Period Beginning: 01/01/13Ending: 12/31/13**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? Yes  
If YES, give association name and amount. Illinois Health Care Association
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x 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. \$ 49,275  
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,440
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? \_\_\_\_\_  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Coffman & Co
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	144,602				1,009	1,009 PETTY C 144,602
1010	CASH IN BANK					1,100	1,100 ACCTS R 584,539
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	584,539				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 78,112
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	78,112				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 138,306
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 1,106,333
1409	LAND	138,306				1,460	0
1450	FURNITURE & EQUIPMENT	1,106,333				1,475	1,475 CODE AI 3,934,346
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM ] (3,829,874)
1475	BUILDING & IMPROVEMEN	3,934,346				1,530	1,530 RESIDEN 7,137
1490	ACCUM DEPR-BUILDING	-3,829,874				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	7,137				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC 41,865
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (106,709)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	41,865				2,100	2,100 ACCRUE (69,536)
2010	ACCOUNTS PAYABLE	-106,709				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-69,536				2,110	2,110 ACCRUE (123,697)
2110	ACCRUED VACATION PAY	-123,697				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	0
2125	FICA TAX PAYABLE	0	0	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(72,731)
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-72,731		2,400	2,400 CURRENT PORTION OF LT DE	
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(7,137)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DE	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINI	(1,805,234)
2460	INCOME TAXES PAYABLE				net incom	(20,322)
2512	DUE TO RESIDENTS	-7,137				
2600	MORTGAGE PAYABLE	0				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-1,805,234				
2970	PROFIT/LOSS FOR PERIOD	-20,322				
3007.1	PATIENT DAYS-PRIVATE	11,978				3,007

3007.2	PATIENT DAYS-IPA	11,513						3,007
3007.3	PATIENT DAYS-MEDICARE	2,007						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-3,897,870	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-26,170	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-124,427	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,016,564	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	953,110	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	0		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-208		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-12,096		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-2,136		0	0	0	0		4,110
3600	21 MISC INCOME	-207		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	243,207	259,693	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	62,037	62,037	17	1	0	0		4,120
4115	VACATION & SICK - G&A	16,486		21	1	0	0		4,125
4120 4475	EMPLOYEE BENEFITS	5,159	514,459	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP	500		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	22,410	22,410	21	2	0	0		4,275
4260	TELEPHONE	10,563	10,563	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	9,072	9,072	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	2,760	3,099	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	49		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	290		24	3	19	-1,100 ***		4,289
4290	HELP WANTED ADVERTISING	2,745	94,737	20	3	0	0 -49,275		4,290
4291	PROMOTIONAL ADVERTISING	23,020		20	3	25	-23,020		4,291
4292	PUBLIC RELATIONS	17,050		20	3	25	-17,050		4,292
4300	LICENSES & FEES	50,154		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	498		20	3	17	-125		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	4,751	211,079	19	3	22	-1,291		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	1,420		10	3	0	0	4,364
4363	PHARMACIST FEES	4,189		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	4,943	4,943	12	3	0	0	4,383
4370	TV RENTAL	11,986		35	3	5	0	4,390
4380	INCOME TAXES		325	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,270		20	3	26	0	4,401
4400	PAYROLL TAXES	177,961		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	6,439		22	3	0	0	4,420
4410	GROUP INSURANCE	217,383		22	3	0	0	4,430
4420	LIABILITY INSURANCE	124,401	124,401	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	107,017		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	206,328		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	325		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	0	11,986	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	75,952	80,750	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,798		6	1	0	0	4,510
5130	ELECTRIC	43,041	83,047	5	3	0	0	4,600
5131	NATURAL GAS	30,637		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	9,369		5	3	0	0	5,130
5134	TRASH COLLECTION	33,970	78,861	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	40,790	70,925	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	30,135		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	44,891		6	3	0	0	5,140
5210	DIETARY WAGES	193,189	202,495	1	1	0	0	5,160
5220	DIETARY SICK & VAC	9,306		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	187,614	181,174	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	9,766	22,199	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	4,785		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,648		1	2	0	0	5,260
5295	MEAL CREDIT	-6,440		2	2	0	0	5,270
5310	LAUNDRY WAGES	50,775	54,348	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,573		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	4,887	14,333	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	9,446		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	84,824	88,967	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	4,143		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	31,892	34,179	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	2,287		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,559,712	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	172,593		10	1	0	0	6,020
6030	DON WAGES	75,647		10	1	0	0	6,030
6035	ADON	69,504		10	1	0	0	6,035
6040	RN SICK & VACATION	20,456		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	497,192		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	32,697		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	594,013		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	34,222		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	58,446		10	1	0	0	6,390
6275	REHAB SICK & VAC	4,942		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	65,109	92,727	10	2	0	0	7,281
6295	NURSING SUPPLIES	18,053		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	9,565		10	2	0	0	7,391
6490	NURSING OTHER	385	5,994	10	3	0	0	7,393
7280	DRUG PURCHASES	68,428	70,908	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	2,361		39	2			7,540
7380	LABORATORY SERVICES	25,893	320,774	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	46,916	49,964	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	3,048		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	5,166	5,166	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	123,235		39	3	0	0 ***	7,890
7660	PT SUPPLIES	119		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	38,333	40,688	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	2,355		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	18	18	12	2	0	0	8,130
7740	OT FEE	124,766		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	46,880		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	0	0	32	3	14	-19,100	
8130	DEPRECIATION	151,128	151,128	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-19,100		32	0	10	0	
9520	MISC NON-OPERATING INC	-424,000		0	0	0	0	
9700	INCOME TAXES	185		0	0	0	0	
		4,106,246	4,549,161					
			442,915					

GRAND TOTALS -20,322 -61,686  
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 90

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP 11,978

11,978

IPA 11,513

11,513

medicare 2,007

2,007

25,498

IPA BEDHOLDS 0

PP BEDHOLDS 0

PP CONVERS 0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT	11,513
3,007 PATIENT	2,007
	0

3,010 BASIC CH	(3,897,870)
----------------	-------------

3,020 BASIC CH	0
----------------	---

3,030 BASIC CH	0
----------------	---

	0
--	---

	0
--	---

	0
--	---

	0
--	---

3,080 NURSING	(26,170)
---------------	----------

3,081 NURSING	0
---------------	---

3,082 NURSING	0
---------------	---

3,083 NURSING	0
---------------	---

3,100 DRUGS-M	(124,427)
---------------	-----------

	0
--	---

3,110 PHYSICAL	(1,016,564)
----------------	-------------

	0
--	---

3,112 PHYSICAL	0
----------------	---

3,113 PHYSICAL	0
----------------	---

3,140 LABORATORY INCOME	
-------------------------	--

	0
--	---

3,152 ST/OT TH	0
----------------	---

3,153 ST/OT TH	0
----------------	---

3,185 REHAB/ISOLATION/OTHER CHG	
---------------------------------	--

3,410 IPA/OTHE	0
----------------	---

3,411 MEDICAR	0
---------------	---

3,420 MEDICAR	930,904
---------------	---------

3,520 RENT INC	0
3,530 BEAUTY :	0
	(208)
3,570 VENDING	0
3,590 EQUIPME	(12,096)
3,595 RESIDENT	(2,136)
3,600 MISC INC	(207)
4,110 G&A WAC	243,207
4,111 ADMINIS'	62,037
4,115 G&A PTO	16,486
4,120 EMPLOYE	5,159
4,130 EMPLOYE	0
4,135 EMPLOYE	500
4,250 OFFICE SI	7,485
4,255 POSTAGE	2,337
4,260 TELEPHO	10,563
4,275 TRAINING	9,072
	(20)
4,280 GENERAL	2,760
4,281 MEAL EX	49
4,285 EDUCATI	290
4,289 MEETING	0
4,290 HELP WA	2,745
4,291 PROMOTI	23,020
4,292 PUBLIC R	17,050
4,300 LICENSE	50,154
4,310 DUES & S	498
4,320 CONTRIB	0
4,350 PROFESSI	4,751
4,355 MEDICAL	12,000
	1,420
	4,189

4,364 SOCIAL S	4,943
4,370 TV RENTL	11,986
4,383 BACKGR	1,270
4,390 OTHER T	0
4,400 PAYROLL	177,961
4,401 PAYROLL	6,439
4,410 GROUP IN	217,383
4,420 LIABILIT	124,401
4,430 WORKMA	105,762
4,435 W/C-FIRS	400
4,436 DRUG TE	875
4,450 MANAGE	206,328
4,460 BAD DEB'	0
4,461 BAD DEB'	22,206
4,470 LOST ITE	325
4,475 UNIFORM	0
4,486 SERVICE	21,671
4,490 MISC EXP	1,657
4,496 MISC. M.I	12,588
4,510 REAL EST	0
4,600 LEASED F	0
5,110 MAINTEN	75,952
5,120 MAINTEN	4,798
5,130 ELECTRIC	43,041
5,131 NATURAL	30,637
5,133 WATER &	9,369
5,134 TRASH CO	33,970
5,140 PROP/PLA	40,790
5,160 GENERAL	30,135
5,165 MAINTEN	23,220
5,210 DIETARY	193,189
5,220 DIETARY	9,306
5,248 FOOD PUI	185,957

5,250 SUPPLIES	9,766
5,260 REPLACE	4,785
5,270 KITCHEN	7,648
5,295 MEAL INC	(6,440)
5,310 LAUNDRY	50,775
5,340 LAUNDRY	3,573
5,370 REPLACE	4,887
	0
5,390 SUPPLIES	9,446
5,410 HOUSEKE	84,824
5,440 HOUSEKE	4,143
5,480 SUPPLIES	31,892
5,490 SUPPLIES	2,287
6,020 RN WAGE	172,593
6,030 DON WAG	75,647
6,035 ADON WA	69,504
6,040 RN PTO &	20,456
6,120 LPN WAG	497,192
6,140 LPN PTO	32,697
6,220 AIDES WA	594,013
6,240 AIDES PT	34,222
	0
	0
	0
6,270 REHAB W	58,446
6,275 REHAB P	4,942
6,290 NURSING	65,109
6,295 NURSING	18,053
6,390 REPLACE	9,565
6,490 OTHER	385

7,280 DRUG PU	68,428
7,281 DRUG PU	2,361
7,380 LABORAT	9,190
7,390 X-RAY SE	3,188
	13,515
7,510 ACTIVITI	46,916
7,540 ACTIVITI	3,048
7,590 ACTIVITI	5,166
7,620 PHYSICAL	123,235
7,660 P.T. SUPP	119
7,710 SOCIAL S	38,333
7,720 SOCIAL S	2,355
7,730 SOCIAL S	18
7,740 OCCUPAT	124,766
7,770 SPEECH T	46,880
7,820 BEAUTIC	0
	0
	0
8,120 INTEREST	0
	0
8,130 DEPRECL	151,128
	0
9,510 INTEREST	(19,100)
9,520 MISC NOI	185
4,220	0
8,100	0
9,702	(424,000)
5,230	0
	<u>(20,322)</u>

Expenses Fixed Assets

