

		FOR BHF USE					

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0048843</u></p> <p>Facility Name: <u>Heritage Health-Beardstown</u></p> <p>Address: <u>8306 St Lukes Drive</u> <u>Beardstown</u> <u>62618</u> Number City Zip Code</p> <p>County: <u>Cass</u></p> <p>Telephone Number: <u>(217) 323-4055</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2007</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dave Underwood</u> Telephone Number: <u>309 823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP & CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP & CFO</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP & CFO</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Heritage Health-Beardstown

0048843 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	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	12,963	7,860	2,645	23,468	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,963	7,860	2,645	23,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.39%

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 July 2007

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 2,645

Medicare Intermediary WPS

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 & ID Number

Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	210,373	7,185		217,558		217,558	3,981	221,539		1
2	Food Purchase		232,143		232,143		232,143	47	232,190		2
3	Housekeeping	82,562	25,754		108,316		108,316		108,316		3
4	Laundry	57,115	7,426		64,541		64,541		64,541		4
5	Heat and Other Utilities			198,521	198,521		198,521	1,086	199,607		5
6	Maintenance	94,454	81,433	57,494	233,381		233,381	13,564	246,945		6
7	Other (specify):*										7
8	TOTAL General Services	444,504	353,941	256,015	1,054,460		1,054,460	18,678	1,073,138		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,324,333	97,492	7,909	1,429,734		1,429,734	231	1,429,965		10
10a	Therapy		464,309	456,859	921,168	(492,058)	429,110		429,110		10a
11	Activities	57,157	5,382		62,539		62,539		62,539		11
12	Social Services	32,176		3,670	35,846		35,846		35,846		12
13	CNA Training							670	670		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,413,666	567,183	471,438	2,452,287	(492,058)	1,960,229	901	1,961,130		16
	C. General Administration										
17	Administrative	76,300			76,300		76,300		76,300		17
18	Directors Fees										18
19	Professional Services			244,743	244,743		244,743	(226,080)	18,663		19
20	Dues, Fees, Subscriptions & Promotions			107,246	107,246	(43,253)	63,993	(14,901)	49,092		20
21	Clerical & General Office Expenses	135,953	19,459	14,083	169,495		169,495	244,168	413,663		21
22	Employee Benefits & Payroll Taxes			502,427	502,427		502,427	40,188	542,615		22
23	Inservice Training & Education			6,500	6,500		6,500	1,193	7,693		23
24	Travel and Seminar			6,371	6,371		6,371	(1,372)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,126	49,126		49,126	8,996	58,122		26
27	Other (specify):*			18,810	18,810		18,810	(18,000)	810		27
28	TOTAL General Administration	212,253	19,459	949,306	1,181,018	(43,253)	1,137,765	34,192	1,171,957		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,070,423	940,583	1,676,759	4,687,765	(535,311)	4,152,454	53,771	4,206,225		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						252,784	252,784			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			16,478	16,478		16,478	88,987	105,465		32
33	Real Estate Taxes							42,085	42,085		33
34	Rent-Facility & Grounds			459,900	459,900		459,900	(516,793)	(56,893)		34
35	Rent-Equipment & Vehicles			2,226	2,226		2,226	6,350	8,576		35
36	Other (specify):*										36
37	TOTAL Ownership			478,604	478,604		478,604	(126,587)	352,017		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					492,058	492,058	37,611	529,669		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					43,253	43,253		43,253		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers					535,311	535,311	37,611	572,922		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,070,423	940,583	2,155,363	5,166,369		5,166,369	(35,205)	5,131,164		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 Heritage Health-Beardstown

0048843

Report Period Beginning: 01/01/14

Ending: 12/31/14

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-	BHF USE	
			ence	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	(61,913)			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	(17,726)			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	(2,367)			17
18	Fines and Penalties				18
19	Entertainment	(7,698)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,711)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(18,971)			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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,386)		\$	30

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

		1	2	
		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)	95,181		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 95,181		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (35,205)		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

Heritage Health-Beardstown

ID# 0048843

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line Reference

NON-ALLOWABLE EXPENSES

Amount

Reference

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		(2,367)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,711)	19	22
23				23
24		(18,000)	27	24
25		(18,971)	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	Total		(43,049)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Beardstown# 0048843

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,981	0	0	0	0	0	0	0	0	3,981	1
2	Food Purchase	0	0	47	0	0	0	0	0	0	0	0	47	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	1,086	0	0	0	0	0	0	0	0	1,086	5
6	Maintenance	0	0	13,564	0	0	0	0	0	0	0	0	13,564	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	18,678	0	0	0	0	0	0	0	0	18,678	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	231	0	0	0	0	0	0	0	0	231	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	670	0	0	0	0	0	0	0	0	670	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	901	0	0	0	0	0	0	0	0	901	16
	C. General Administration													
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	(3,711)	(238,391)	16,022	0	0	0	0	0	0	0	0	(226,080)	19
20	Fees, Subscriptions & Promotions	(21,338)	0	6,437	0	0	0	0	0	0	0	0	(14,901)	20
21	Clerical & General Office Expenses	0	0	244,168	0	0	0	0	0	0	0	0	244,168	21
22	Employee Benefits & Payroll Taxes	0	0	40,188	0	0	0	0	0	0	0	0	40,188	22
23	Inservice Training & Education	0	0	1,193	0	0	0	0	0	0	0	0	1,193	23
24	Travel and Seminar	(7,698)	0	6,326	0	0	0	0	0	0	0	0	(1,372)	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	8,996	0	0	0	0	0	0	0	0	8,996	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	TOTAL General Administration	(50,747)	(238,391)	323,330	0	0	0	0	0	0	0	0	34,192	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,747)	(238,391)	342,909	0	0	0	0	0	0	0	0	53,771	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14 Ending:

12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	236,826	0	15,958	0	0	0	0	0	0	0	252,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,726)	106,733	0	(20)	0	0	0	0	0	0	0	88,987	32
33	Real Estate Taxes	0	42,085	0	0	0	0	0	0	0	0	0	42,085	33
34	Rent-Facility & Grounds	(61,913)	(459,900)	0	5,020	0	0	0	0	0	0	0	(516,793)	34
35	Rent-Equipment & Vehicles	0	0	0	6,350	0	0	0	0	0	0	0	6,350	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(79,639)	(74,256)	0	27,308	0	(126,587)	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	37,611	0	0	0	0	0	0	0	0	0	37,611	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	37,611	0	0	0	0	0	0	0	0	0	37,611	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(130,386)	(275,036)	342,909	27,308	0	(35,205)	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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attached-See Following Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt Svcs</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	

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	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>37,611</u>	<u>37,611</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>238,391</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(238,391)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>459,900</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(459,900)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>42,085</u>	<u>42,085</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>101,960</u>	<u>101,960</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>236,826</u>	<u>236,826</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 698,291			\$ 423,255	\$ * (275,036)	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	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$ 3,981	15
16	V	2 Food Purchase					47	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,086	19
20	V	6 Maintenance					13,564	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					231	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					670	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					0	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					16,022	31
32	V	20 Fees, Subscription, Promotions					6,437	32
33	V	21 Clerical & General Office Expenses					244,168	33
34	V	22 Employee Benefits & Payroll Taxes					40,188	34
35	V	23 Inservice Training & Education					1,193	35
36	V	24 Travel and Seminar					6,326	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					8,996	38
39	Total		\$			\$	0	\$ * 342,909 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	27 Other	\$	Heritage Enterprises, Inc.		\$	\$	0 15
16	V	30 Depreciation						15,958 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						(20) 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						5,020 20
21	V	35 Rent-Equipment & Vehicles						6,350 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	0	\$ * 27,308 39

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

Facility Name & ID Number Heritage Health-Beardstown # 0048843 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Heritage Enterprises Inc.	Sole Member		100.00					\$	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 Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

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	Dietary	Beds	2,666	25	\$ 134,342	\$ 134,342	79	\$ 3,981	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	79	47	2
3	3	Housekeeping	Beds	2,666	25	0	0	79	0	3
4	4	Laundry	Beds	2,666	25	0	0	79	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	79	1,086	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	79	13,564	6
7	7	Other	Beds	2,666	25	0	0	79	0	7
8	9	Medical Director	Beds	2,666	25	0	0	79	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	79	231	9
10	11	Activities	Beds	2,666	25	0	0	79	0	10
11	12	Social Service	Beds	2,666	25	0	0	79	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	79	670	12
13	14	Program Transportation	Beds	2,666	25	0	0	79	0	13
14	15	Other	Beds	2,666	25	0	0	79	0	14
15	17	Administrative	Beds	2,666	25	0	0	79	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	79	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	79	16,022	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	79	6,437	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	79	244,168	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	79	40,188	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	79	1,193	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	79	6,326	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	79	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	79	8,996	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 342,909	25

Facility Name & ID Number Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization See PG 3
 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	27	Other	Beds	2,666	25	\$	79	\$	1
2	30	Depreciation	Beds	2,666	25	538,548	79	15,958	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25		79		3
4	32	Interest	Beds	2,666	25	(682)	79	(20)	4
5	33	Real Estate Taxes	Beds	2,666	25		79		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393	79	5,020	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306	79	6,350	7
8	36	Other	Beds	2,666	25		79		8
9	38	Medically Nec Transportation	Beds	2,666	25		79		9
10	39	Ancillary Service Centers	Beds	2,666	25		79		10
11	40	Barber and Beauty Shops	Beds	2,666	25		79		11
12	41	Coffee and Gift Shops	Beds	2,666	25		79		12
13	42	Other	Beds	2,666	25		79		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				\$ 921,565	\$		\$ 27,308	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					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	Bank of America		x	Mortgage			\$	\$			\$ 101,960	1					
2	Bank of America		x	Loan Fee Amortization							4,773	2					
3												3					
4												4					
5												5					
Working Capital																	
6	Bank of America		x	Working Capital							16,478	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$			\$ 123,211	9					
B. Non-Facility Related*																	
10	Interest Income										(17,726)	10					
11												11					
12	Allocated Corporate										(20)	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (17,746)	14					
15	TOTALS (line 9+line14)						\$	\$			\$ 105,465	15					

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.		\$			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.)		\$	42,085		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	42,085		3	
4. Real Estate Tax accrual used for 2014 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. (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.		\$	42,085		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	_____	8	FOR BHF USE ONLY		
	2010	_____	9			
	2011	40,275	10			
	2012	40,926	11			
	2013	42,085	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Beardstown COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0048843

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>0301101200</u>	_____	\$ <u>36,511.14</u>	\$ <u>36,511.14</u>
2. <u>0301101201</u>	_____	\$ <u>5,573.38</u>	\$ <u>5,573.38</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>42,084.52</u></u>	\$ <u><u>42,084.52</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Heritage Health-Beardstown

0048843 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,196 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
Evergreen Place SLF - 26 Apartments

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				\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	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	79				\$ 1,380,636	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	Remodel facility--Materials & Labor		1997		272,458					
10										
11	Nurse Call System		1997		1,500					
12										
13	Remodel facility--Materials & Labor		1998		85,772					
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27	Door Alarm System		2000		2,727					
28	A/C Compressor		2000		2,984					
29	Compressor -- Walk-in Freezer		2000		2,586					
30	Water Heater		2000		2,804					
31										
32										
33	C/O Allocation					15,958		15,958		
34	Book Depreciation					183,917		183,917		
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

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	Recirculating Pump	2001	\$ 889	\$		\$	\$	\$	37
38	West entrance Door	2001	1,700						38
39									39
40	Door	2002	2,840						40
41	a/c unit	2002	15,900						41
42	Shower room Wall	2002	1,200						42
43	Cmpressor	2002	13,348						43
44									44
45	Sewer Relocation	2002	2,011						45
46									46
47	Sewer Relocation	2003	2,206						47
48	a/c units	2003	10,170						48
49									49
50	Disposer	2003	1,454						50
51	A/C Unit	2003	5,786						51
52	Rebuild Generator	2003	4,276						52
53									53
54	Exterior doors	2004	3,212						54
55	Shower room Remodel	2004	9,028						55
56	Landscapping	2004	3,030						56
57	Canopy	2004	570						57
58	Door	2004	1,068						58
59	A/C Unit	2004	7,326						59
60	Heat/Cool Units	2004	6,960						60
61	Carpet	2004	911						61
62	Compressor	2004	2,949						62
63	Chiller	2004	1,970						63
64	Drier Core	2004	953						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,851,224	\$ 199,875		\$ 199,875	\$	\$	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		\$ 1,851,224	\$ 199,875		\$ 199,875	\$	\$	1
2	Shower Remodel	2005	7,273						2
3	Ansul System	2005	2,540						3
4									4
5									5
6	Interior rehab -- Labor and Materials	2005	28,299						6
7	Delayed Egress Magnet	2005	2,092						7
8	Panic Door Hardware	2005	2,125						8
9	Roof repair	2005	3,702						9
10									10
11									11
12	Door opener	2006	2,445						12
13	Wanderguard system	2006	2,267						13
14	Hot water heater	2006	13,771						14
15	Sidewalk	2006	4,928						15
16									16
17	Hvac	2006	17,853						17
18									18
19	Alarm system	2006	6,568						19
20	Generater regulator	2006	1,727						20
21	Awning	2006	4,264						21
22	Closet door	2006	2,722						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)		\$ 1,953,800	\$ 199,875		\$ 199,875	\$	\$	34

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

Facility Name & ID Number Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,953,800	\$ 199,875		\$ 199,875	\$	\$	1
2	<u>HVAC</u>	2007	9,672						2
3	<u>Chiller</u>	2007	2,603						3
4									4
5	Post 6/30/07 capital review								5
6	<u>Landscaping</u>	2007	28,000						6
7	<u>Water Heater</u>	2007	21,682						7
8	<u>Rooftop A/C</u>	2007	205						8
9	<u>Blinds</u>	2007	845						9
10	<u>Roof fans</u>	2007	3,457						10
11	<u>A/C</u>	2007	12,487						11
12	<u>Doors</u>	2007	3,358						12
13	<u>Generator</u>	2007	39,004						13
14	<u>Wall Heater</u>	2007	3,384						14
15	<u>Circulating pump</u>	2007	896						15
16	<u>Roof</u>	2007	141,801						16
17	<u>Capital report Adj</u>	2007	(216,315)						17
18	<u>HVAC Rooftop Unit</u>	2008	148,000						18
19	<u>Water Heater</u>	2008	14,252						19
20	<u>Heater Replacement</u>	2008	4,008						20
21	<u>Resident Room Remodel-- Painting, Lighting</u>	2008	75,015						21
22	<u>Hot Water Heater</u>	2008	6,621						22
23	<u>HVAC Units</u>	2008	19,280						23
24	<u>Electric Heater</u>	2008	5,195						24
25	<u>Capital report Adj</u>	2008	(50,625)						25
26	<u>Elevator</u>	2009	9,873						26
27	<u>Mixing valve</u>	2009	3,715						27
28	<u>Room painting</u>	2009	6,065						28
29	<u>Comdensor</u>	2009	5,260						29
30	<u>Lights</u>	2009	4,055						30
31	<u>Parking Lot</u>	2009	83,790						31
32	<u>Flooring</u>	2009	18,770						32
33	<u>Nurse Call System</u>	2009	107,659						33
34	TOTAL (lines 1 thru 33)		\$ 2,465,812	\$ 199,875		\$ 199,875	\$	\$	34

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

Facility Name & ID Number Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,465,812	\$ 199,875		\$ 199,875	\$	\$	1
2	Capital Report Adj	2009	(16,907)						2
3	Electric reheats	2010	4,647						3
4	HVAC units	2010	15,119						4
5	Insulation	2010	34,950						5
6	Parking Lot	2010	23,462						6
7	Nurse Call System	2010	183,517						7
8									8
9	Sprinkler	2011	63,196						9
10	Roof	2011	133,678						10
11	Heat/cool Units	2011	19,980						11
12	water tank	2011	7,503						12
13	Heat Panel	2011	5,003						13
14	sign	2011	22,000						14
15									15
16	Roof Replacement	2012	19,770						16
17	Water Heater	2012	13,243						17
18	Compressor	2012	14,538						18
19	Lighting	2012	22,130						19
20									20
21	Compressor Replacements	2013	10,494						21
22	Elevator Door Restrictor	2013	3,150						22
23	Replace Heat Controls	2013	4,940						23
24	Sprinkler System Installation	2013	20,005						24
25	Duct Heater Replacement	2013	3,341						25
26									26
27	Elevator Door Restrictor-Final Payment	2014	3,150						27
28	Replace Dishwasher	2014	5,478						28
29	Roof Replacement	2014	173,569						29
30	Rebuild Fan Motor	2014	3,608						30
31	Chiller Replacement	2014	150,950						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,410,326	\$ 199,875		\$ 199,875	\$	\$	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	\$ 1,012,253	\$ 52,909	\$ 52,909	\$		\$	71
72	Current Year Purchases	11,793						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,024,046	\$ 52,909	\$ 52,909	\$		\$	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)	\$ 4,459,372	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 252,784	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 252,784	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.

Facility Name & ID Number Heritage Health-Beardstown

0048843

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 2,226 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	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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			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	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	\$			\$ 174,538	\$		\$ 174,538	1
2	Licensed Speech and Language Development Therapist		hrs				65,203			65,203	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				189,369	0		189,369	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					464,309		464,309	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						27,749			27,749	13
14	TOTAL			\$			\$ 456,859	\$ 464,309		\$ 921,168	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 Heritage Health-Beardstown

0048843

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,926	\$	1
2	Cash-Patient Deposits	9,728		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	714,240		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,122		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,024,234)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (261,218)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (261,218)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 216,958	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,728		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	253,506		30
31	Accrued Taxes Payable (excluding real estate taxes)	(21,669)		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
Other Current Liabilities(specify):				
36	<u>Assessment Tax</u>	52,979		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 511,502	\$	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)	\$ 511,502	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (772,720)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (261,218)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (964,954)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (964,954)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	192,234	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)	\$ 192,234	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)	\$ (772,720)	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	\$ 4,093,227	1
2	Discounts and Allowances for all Levels	(1,656,916)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,436,311	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,419,426	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,419,426	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	891	12
13	Barber and Beauty Care	863	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	61,913	16
17	Sale of Drugs	894,408	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19,268	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 977,343	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,726	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,726	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SLF	507,797	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 507,797	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,358,603	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,054,460	31
32	Health Care	2,452,287	32
33	General Administration	1,181,018	33
B. Capital Expense			
34	Ownership	478,604	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,166,369	40
41	Income before Income Taxes (line 30 minus line 40)**	192,234	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 192,234	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	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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 Heritage Health-Beardstown

0048843

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,838	1,976	\$ 62,065	\$ 31.41	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,244	8,865	252,794	28.52	3
4	Licensed Practical Nurses	16,389	17,622	365,552	20.74	4
5	CNAs & Orderlies	54,665	58,780	595,199	10.13	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,762	1,894	48,723	25.72	8
9	Activity Director					9
10	Activity Assistants	3,940	4,236	57,157	13.49	10
11	Social Service Workers	1,808	1,944	32,176	16.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,415	18,726	210,373	11.23	15
16	Dishwashers					16
17	Maintenance Workers	5,406	5,813	94,454	16.25	17
18	Housekeepers	7,411	7,969	82,562	10.36	18
19	Laundry	4,505	4,844	57,115	11.79	19
20	Administrator	1,934	2,080	76,300	36.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,589	10,311	135,953	13.19	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)	134,906	145,060	\$ 2,070,423 *	\$ 14.27	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	3,000		36
37	Medical Records Consultant	1,440		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,300		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	3,670		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 14,410		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 Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 43,253
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. \$ 417
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
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. \$ _____
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (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. None Claimed
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 Line #	Sch 5 pg Col #	Sch 6 pg Line #	Adjustment Amount			
1009	PETTY CASH	1,926						1,009	1,009	PETTY CASH 1,926
1010	CASH IN BANK							1,100	1,100	ACCTS R 714,240
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	714,240						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 37,122
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	37,122						1,310	1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY
1300	FOOD INVENTORY							1,409	1,409	LAND 0
1310	SUPPLIES INVENTORY							1,450	1,450	FURNITU 0
1409	LAND	0						1,460		0
1450	FURNITURE & EQUIPMENT	0						1,475	1,475	CODE AL 0
1460	ACCUM DEPR-FURN & EQUIP	0						1,490	1,490	ACCUM I 0
1475	BUILDING & IMPROVEMENTS	0						1,530	1,530	RESIDEN 9,728
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FE 0
1530	RESIDENT FUNDS	9,728						1,551	1,551	LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850	INTERCO (1,024,234)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN (216,958)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
1850	INTRACOMPANY	-1,024,234						2,100	2,100	ACCRUEI (118,611)
2010	ACCOUNTS PAYABLE	-216,958						2,100	2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-118,611						2,110	2,110	ACCRUEI (134,895)
2110	ACCRUED VACATION PAY	-134,895						2,120	2,120	U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	21,669
2125	FICA TAX PAYABLE	21,669	21,669	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 REFUND	
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 - CAFETERIA	
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 GARNISHMENTS	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUED INTEREST	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYMENTS	(52,979)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL ESTATE TAX	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-52,979		2,400	2,400 CURRENT PORTION OF LT DEBT	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO FUND	(9,728)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	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 DEBT	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED EARNINGS	964,954
2460	INCOME TAXES PAYABLE				net income	(192,234)
2512	DUE TO RESIDENTS	-9,728				
2600	MORTGAGE PAYABLE	0			balance	<u>0</u>
2650	EQUIPMENT LOAN PAYABLE					
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	964,954				
2970	PROFIT/LOSS FOR PERIOD	-192,234				
3007.1	PATIENT DAYS-PRIVATE	7,860				3,007

3007.2	PATIENT DAYS-IPA	12,963						3,007
3007.3	PATIENT DAYS-MEDICARE	2,645						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 & VA	-4,069,878	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-MEDICARE	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-PRIVATE	-11,404	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	-894,408	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,419,426	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	1,656,916	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	-61,913		6	0	6	-61,913		3,530
3530	13 BEAUTY SHOP	-863		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-450		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-441		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-11,945		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-19,268		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	125,260	135,953	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	76,300	76,300	17	1	0	0		4,120
4115	VACATION & SICK - G&A	10,693		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	12,264	502,427	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	3,829		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP COST	1,873		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255 OFFICE SUPPLIES	19,459	19,459	21	2	0	0		4,275
4260	TELEPHONE	14,083	14,083	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	6,500	6,500	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	3,555	6,371	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	1,010		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,806		24	3	19	-7,698 ***		4,289
4290	HELP WANTED ADVERTISING	2,958	107,246	20	3	0	0 -43,253		4,290
4291	PROMOTIONAL ADVERTISING	7,817		20	3	25	-7,817		4,291
4292	PUBLIC RELATIONS	11,154		20	3	25	-11,154		4,292
4300	LICENSES & FEES	76,076		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	7,593		20	3	17	-2,367		4,310
4320	CONTRIBUTIONS	525		27	3	20	0		4,320
4350	PROFESSIONAL FEES	6,352	244,743	19	3	22	-3,711		4,350
4355	MEDICAL DIRECTOR	3,000	3,000	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 CONSULT	1,440		10	3	0	0	4,364
4363	PHARMACIST FEES	6,300		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,670	3,670	12	3	0	0	4,383
4370	TV RENTAL	-1,027		35	3	5	0	4,390
4380	INCOME TAXES		18,810	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,648		20	3	26	0	4,401
4400	PAYROLL TAXES	203,398		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	7,920		22	3	0	0	4,420
4410	GROUP INSURANCE	241,344		22	3	0	0	4,430
4420	LIABILITY INSURANCE	49,126	49,126	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	31,799		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	238,391		19	3	34	0 **	4,460
4460	BAD DEBTS	18,000		27	3	24	-18,000	4,461
4470	LOST ITEMS-RESIDENTS	285		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	3,253	2,226	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	88,141	94,454	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	6,313		6	1	0	0	4,510
5130	ELECTRIC	189,447	198,521	5	3	0	0	4,600
5131	NATURAL GAS	0		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	9,074		5	3	0	0	5,130
5134	TRASH COLLECTION	12,631	57,494	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	15,861	81,433	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	65,572		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	44,863		6	3	0	0	5,140
5210	DIETARY WAGES	194,962	210,373	1	1	0	0	5,160
5220	DIETARY SICK & VAC	15,411		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	232,560	232,143	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	1,598	7,185	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,308		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	2,279		1	2	0	0	5,260
5295	MEAL CREDIT	-417		2	2	0	0	5,270
5310	LAUNDRY WAGES	53,668	57,115	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,447		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	2,659	7,426	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	4,767		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	75,183	82,562	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	7,379		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	23,107	25,754	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	2,647		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,324,333	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	231,426		10	1	0	0	6,020
6030	DON WAGES	62,065		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	21,368		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	339,117		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	26,435		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	551,882		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	43,317		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 WAGES	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 REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	44,335		10	1	0	0	6,390
6275	REHAB SICK & VAC	4,388		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	19,679	97,492	10	2	0	0	7,281
6295	NURSING SUPPLIES	75,468		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	2,345		10	2	0	0	7,391
6490	NURSING OTHER	169	7,909	10	3	0	0	7,393
7280	DRUG PURCHASES	114,160	464,309	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	350,149		39	2			7,540
7380	LABORATORY SERVICES	27,749	456,859	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	52,841	57,157	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,316		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	5,382	5,382	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	189,369		39	3	0	0 ***	7,890
7660	PT SUPPLIES	0		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	29,781	32,176	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	2,395		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	174,538		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	65,203		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	459,900	459,900	34	3	0	0	

8120	INTEREST EXPENSE	16,478	16,478	32	3	14	-17,726	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-17,726		32	0	10	0	
9520	MISC NON-OPERATING INCOME	-507,797		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

4,640,846 5,166,369
525,523

GRAND TOTALS -192,234 -130,386
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	7,860	7,860
IPA	12,963	12,963
medic	2,645	2,645
		23,468

S

JND

IA

T

T

3,007 PATIENT	12,963
3,007 PATIENT	2,645
	0
3,010 BASIC CI	(4,069,878)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(11,404)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(894,408)
	0
3,110 PHYSICIAN	(1,419,426)
	0
3,112 PHYSICIAN	0
3,113 PHYSICIAN	0
3,140 LABORATORY INCOME	0
	0
3,152 ST/OT TR	0
3,153 ST/OT TR	0
3,185 REHABILITATION/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	1,611,793

3,520 RENT INC	(61,913)
3,530 BEAUTY	(863)
	(450)
3,570 VENDING	(441)
3,590 EQUIPMI	(11,945)
3,595 RESIDEN	(19,268)
3,600 MISC INC	0
4,110 G&A WA	125,260
4,111 ADMINIS	76,300
4,115 G&A PTC	10,693
4,120 EMPLOY	12,193
4,130 EMPLOY	3,829
4,135 EMPLOY	1,873
4,250 OFFICE S	7,735
4,255 POSTAGI	2,336
4,260 TELEPHC	14,083
4,275 TRAININ	6,500
	0
4,280 GENERA	3,555
4,281 MEAL EX	1,010
4,285 EDUCAT	1,217
4,289 MEETING	589
4,290 HELP WA	2,958
4,291 PROMOT	7,817
4,292 PUBLIC I	11,154
4,300 LICENSE	76,076
4,310 DUES & S	7,593
4,320 CONTRIB	525
4,350 PROFESS	6,352
4,355 MEDICAL	3,000
	1,440
	6,300

4,364 SOCIAL S	3,670
4,370 TV RENT	(1,027)
4,383 BACKGR	1,648
4,390 OTHER T	0
4,400 PAYROL	203,398
4,401 PAYROL	7,920
4,410 GROUP I	241,344
4,420 LIABILIT	49,126
4,430 WORKM	30,211
4,435 W/C-FIRS	848
4,436 DRUG TE	740
4,450 MANAGI	238,391
4,460 BAD DEF	18,000
4,461 BAD DEF	45,123
4,470 LOST ITE	285
4,475 UNIFORM	71
4,486 SERVICE	18,059
4,490 MISC EX	395
4,496 MISC. M.	9,388
4,510 REAL ES	0
4,600 LEASED	3,253
5,110 MAINTEI	88,141
5,120 MAINTEI	6,313
5,130 ELECTRI	189,447
5,131 NATURA	0
5,133 WATER &	9,074
5,134 TRASH C	12,631
5,140 PROP/PL	15,861
5,160 GENERA	65,572
5,165 MAINTEI	26,804
5,210 DIETARY	194,962
5,220 DIETARY	15,411
5,248 FOOD PU	232,165

5,250 SUPPLIE	1,598
5,260 REPLACI	3,308
5,270 KITCHEN	2,279
5,295 MEAL IN	(417)
5,310 LAUNDR	53,668
5,340 LAUNDR	3,447
5,370 REPLACI	2,659
	0
5,390 SUPPLIE	4,767
5,410 HOUSEK	75,183
5,440 HOUSEK	7,379
5,480 SUPPLIE	23,107
5,490 SUPPLIE	2,647
6,020 RN WAG	231,426
6,030 DON WA	62,065
6,035 ADON W	0
6,040 RN PTO &	21,368
6,120 LPN WAG	339,117
6,140 LPN PTO	26,435
6,220 AIDES W	551,882
6,240 AIDES PT	43,317
6,245	0
	0
	0
	0
6,270 REHAB V	44,335
6,275 REHAB F	4,388
6,290 NURSINC	19,679
6,295 NURSINC	75,468
6,390 REPLACI	2,345
6,490 OTHER	169

7,280 DRUG PU	114,160
7,281 DRUG PU	350,149
7,380 LABORA	3,637
7,390 X-RAY S	24,112
	0
7,510 ACTIVIT	52,841
7,540 ACTIVIT	4,316
7,590 ACTIVIT	5,382
7,620 PHYSICA	189,369
7,660 P.T. SUPE	0
7,710 SOCIAL S	29,781
7,720 SOCIAL S	2,395
7,730 SOCIAL S	0
7,740 OCCUPA	174,538
7,770 SPEECH '	65,203
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	0
	16,478
8,130 DEPRECI	0
	0
9,510 INTERES	(17,726)
9,520 MISC NO	0
4,220	0
8,100	459,900
9,702	(507,797)
5,230	0
	<u>(192,234)</u>

Expenses Fixed Assets

