



Facility Name & ID Number Heritage Health-Bloomington

# 0048157 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	111	Skilled (SNF)	111	40,515	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	111	TOTALS	111	40,515	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	10,770	10,039	5,054	25,863	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,770	10,039	5,054	25,863	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.84%

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 2006

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 5,054

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.

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	265,987	22,469		288,456		288,456	5,593	294,049		1
2	Food Purchase		193,295		193,295		193,295	66	193,361		2
3	Housekeeping	93,785	31,519		125,304		125,304		125,304		3
4	Laundry	67,728	15,659		83,387		83,387		83,387		4
5	Heat and Other Utilities			113,262	113,262		113,262	1,526	114,788		5
6	Maintenance	92,548	48,954	83,830	225,332		225,332	19,058	244,390		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	520,048	311,896	197,092	1,029,036		1,029,036	26,243	1,055,279		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,828	15,828		15,828		15,828		9
10	Nursing and Medical Records	1,890,874	182,054	32,498	2,105,426		2,105,426	324	2,105,750		10
10a	Therapy		743,072	805,028	1,548,100	(797,193)	750,907		750,907		10a
11	Activities	62,338	2,427		64,765		64,765		64,765		11
12	Social Services	65,685		465	66,150		66,150		66,150		12
13	CNA Training							941	941		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,018,897	927,553	853,819	3,800,269	(797,193)	3,003,076	1,265	3,004,341		16
	<b>C. General Administration</b>										
17	Administrative	80,184			80,184		80,184		80,184		17
18	Directors Fees										18
19	Professional Services			315,786	315,786		315,786	(284,781)	31,005		19
20	Dues, Fees, Subscriptions & Promotions			179,841	179,841	(60,773)	119,068	(86,484)	32,584		20
21	Clerical & General Office Expenses	178,690	27,962	27,383	234,035		234,035	343,072	577,107		21
22	Employee Benefits & Payroll Taxes			622,117	622,117		622,117	56,466	678,583		22
23	Inservice Training & Education			8,069	8,069		8,069	1,676	9,745		23
24	Travel and Seminar			7,815	7,815		7,815	(2,816)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,799	77,799		77,799	12,639	90,438		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	258,874	27,962	1,238,810	1,525,646	(60,773)	1,464,873	39,772	1,504,645		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,797,819	1,267,411	2,289,721	6,354,951	(857,966)	5,496,985	67,280	5,564,265		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	
	<b>D. Ownership</b>											
30	Depreciation							587,592	587,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,562	18,562		18,562	132,881	151,443			32
33	Real Estate Taxes							84,744	84,744			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(486,627)	(447)			34
35	Rent-Equipment & Vehicles			20,337	20,337		20,337	8,923	29,260			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			525,079	525,079		525,079	327,513	852,592			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					797,193	797,193	(171,233)	625,960			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,773	60,773		60,773			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>					857,966	857,966	(171,233)	686,733			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,797,819	1,267,411	2,814,800	6,880,030		6,880,030	223,560	7,103,590			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-Bloomington

# 0048157

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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>BHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
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	(7,500)			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	(18,038)			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	(3,946)			17
18	Fines and Penalties				18
19	Entertainment	(11,705)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,532)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(91,583)			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>	\$ (137,304)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	360,864		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 360,864		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 223,560		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

Heritage Health-Bloomington

ID# 0048157

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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		(3,946)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,532)	19	22
23				23
24		0	27	24
25		(91,583)	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>		(100,061)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Bloomington# 0048157

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	5,593	0	0	0	0	0	0	0	0	5,593	1
2	Food Purchase	0	0	66	0	0	0	0	0	0	0	0	66	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	1,526	0	0	0	0	0	0	0	0	1,526	5
6	Maintenance	0	0	19,058	0	0	0	0	0	0	0	0	19,058	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>26,243</b>	<b>0</b>	<b>26,243</b>	<b>8</b>							
	<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	324	0	0	0	0	0	0	0	0	324	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	941	0	0	0	0	0	0	0	0	941	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>	<b>0</b>	<b>0</b>	<b>1,265</b>	<b>0</b>	<b>1,265</b>	<b>16</b>							
	<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	(4,532)	(302,760)	22,511	0	0	0	0	0	0	0	0	(284,781)	19
20	Fees, Subscriptions & Promotions	(95,529)	0	9,045	0	0	0	0	0	0	0	0	(86,484)	20
21	Clerical & General Office Expenses	0	0	343,072	0	0	0	0	0	0	0	0	343,072	21
22	Employee Benefits & Payroll Taxes	0	0	56,466	0	0	0	0	0	0	0	0	56,466	22
23	Inservice Training & Education	0	0	1,676	0	0	0	0	0	0	0	0	1,676	23
24	Travel and Seminar	(11,705)	0	8,889	0	0	0	0	0	0	0	0	(2,816)	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	12,639	0	0	0	0	0	0	0	0	12,639	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(111,766)</b>	<b>(302,760)</b>	<b>454,298</b>	<b>0</b>	<b>39,772</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(111,766)</b>	<b>(302,760)</b>	<b>481,806</b>	<b>0</b>	<b>67,280</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Bloomington

# 0048157

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	565,169	0	22,423	0	0	0	0	0	0	0	587,592	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,038)	150,947	0	(28)	0	0	0	0	0	0	0	132,881	32
33	Real Estate Taxes	0	84,744	0	0	0	0	0	0	0	0	0	84,744	33
34	Rent-Facility & Grounds	(7,500)	(486,180)	0	7,053	0	0	0	0	0	0	0	(486,627)	34
35	Rent-Equipment & Vehicles	0	0	0	8,923	0	0	0	0	0	0	0	8,923	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(25,538)</b>	<b>314,680</b>	<b>0</b>	<b>38,371</b>	<b>0</b>	<b>327,513</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	(171,233)	0	0	0	0	0	0	0	0	0	(171,233)	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>(171,233)</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>(171,233)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(137,304)</b>	<b>(159,313)</b>	<b>481,806</b>	<b>38,371</b>	<b>0</b>	<b>223,560</b>	<b>45</b>						

**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 Following This Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt. Services</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(171,233)</u>	<u>(171,233)</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>302,760</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(302,760)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>486,180</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(486,180)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>84,744</u>	<u>84,744</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>140,114</u>	<u>140,114</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>565,169</u>	<u>565,169</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>10,833</u>	<u>10,833</u>	10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		<b>\$ 788,940</b>			<b>\$ 629,627</b>	<b>\$ * (159,313)</b>	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.		\$	\$ 5,593	15
16	V	2 Food Purchase					66	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,526	19
20	V	6 Maintenance					19,058	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					324	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					941	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					22,511	31
32	V	20 Fees, Subscription, Promotions					9,045	32
33	V	21 Clerical & General Office Expenses					343,072	33
34	V	22 Employee Benefits & Payroll Taxes					56,466	34
35	V	23 Inservice Training & Education					1,676	35
36	V	24 Travel and Seminar					8,889	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					12,639	38
39	Total		\$			\$	0	\$ * 481,806 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						22,423	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(28)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						7,053	20	
21	V	35 Rent-Equipment & Vehicles						8,923	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								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	38,371	39

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

Facility Name & ID Number

Heritage Health-Bloomington

# 0048157

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

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-Bloomington

# 0048157

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	111	\$ 5,593	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	111	66	2
3	3	Housekeeping	Beds	2,666	25	0	0	111	0	3
4	4	Laundry	Beds	2,666	25	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	111	1,526	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	111	19,058	6
7	7	Other	Beds	2,666	25	0	0	111	0	7
8	9	Medical Director	Beds	2,666	25	0	0	111	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	111	324	9
10	11	Activities	Beds	2,666	25	0	0	111	0	10
11	12	Social Service	Beds	2,666	25	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	111	941	12
13	14	Program Transportation	Beds	2,666	25	0	0	111	0	13
14	15	Other	Beds	2,666	25	0	0	111	0	14
15	17	Administrative	Beds	2,666	25	0	0	111	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	111	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	111	22,511	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	111	9,045	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	111	343,072	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	111	56,466	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	111	1,676	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	111	8,889	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	111	12,639	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 481,806	25

Facility Name & ID Number Heritage Health-Bloomington

# 0048157

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 8

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	\$	\$	111	\$	1
2	30	Depreciation	Beds	2,666	25	538,548		111	22,423	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25			111		3
4	32	Interest	Beds	2,666	25	(682)		111	(28)	4
5	33	Real Estate Taxes	Beds	2,666	25			111		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393		111	7,053	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306		111	8,923	7
8	36	Other	Beds	2,666	25			111		8
9	38	Medically Nec Transportation	Beds	2,666	25			111		9
10	39	Ancillary Service Centers	Beds	2,666	25			111		10
11	40	Barber and Beauty Shops	Beds	2,666	25			111		11
12	41	Coffee and Gift Shops	Beds	2,666	25			111		12
13	42	Other	Beds	2,666	25			111		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	\$		\$ 38,371	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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Bank of America		x	Mortgage			\$	\$			\$ 140,114	1					
2	Bank of America		x	Loan Fee Amortization							10,833	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Bank of America		x	Working Capital							18,562	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 169,509	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income										(18,038)	10					
11												11					
12	Allocated Corporate										(28)	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (18,066)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 151,443	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**

		<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 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.)		\$	84,744		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	84,744		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. <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.		\$	84,744		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td>16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		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
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010	_____	9																
	2011	81,020	10																
	2012	81,153	11																
	2013	84,744	12																

**NOTES:**

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

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

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>2104227012</u>	_____	\$ 83,910.00	\$ 83,910.00
2. <u>2104227010</u>	_____	\$ 417.36	\$ 417.36
3. <u>2104227009</u>	_____	\$ 417.36	\$ 417.36
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>84,744.72</u>	\$ <u>84,744.72</u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 25,183 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).

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				\$ 116,576	1
2				138,502	2
3	TOTALS			\$ 255,078	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	Accumulated Depreciation
4	111			\$ 560,548	\$		\$	\$
5				221,147				
6								
7								
8								
Improvement Type**								
9	1978 Improvements	1978		14,607				
10	1979 Improvements	1979		95,460				
11	1980 Improvements	1980		75,591				
12	1981 Improvements	1981		11,544				
13	1982 Improvements	1982		9,256				
14	1983 Improvements	1983		13,130				
15	1984 Improvements	1984		7,215				
16	1985 Improvements	1985		45,885				
17	1986 Improvements	1986		13,469				
18	1988 Improvements	1988		83,109				
19	1989 Improvements	1989		2,439				
20	1990 Improvements	1990		30,676				
21	1991 Improvements	1991		4,207				
22	1992 Improvements	1992		1,208				
23	1993 Improvements	1993		97,303				
24	1994 Improvements	1994		29,638				
25	1995 Improvements	1995		121,304				
26	BOILER	1996		17,850				
27	EXHAUST HOOD	1996		1,075				
28	CODE ALERT	1996		1,852				
29	PHONE SYSTEM	1996		2,339				
30	INTERIOR REMODEL	1996		103,103				
31								
32								
33	C/O Allocation				22,423		22,423	
34	Book Depreciation				402,076		402,076	
35								
36								

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health-Bloomington

# 0048157

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	
37	Interior Rehab--paint, wallpaper, remodel facility	1997	\$ 211,945	\$		\$	\$	\$	37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63	Adj to Capital Report	2000	(2,383)						63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,187,775	\$ 424,499		\$ 424,499	\$	\$	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		\$ 3,187,775	\$ 424,499		\$ 424,499	\$	\$	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9	Smoke Detectors and Installation	2002	14,551						9
10	Mixing valve	2002	1,862						10
11	Main Corridor Rehab (Wallcovering)	2002	3,885						11
12	Floor Tile	2002	1,280						12
13	Kitchen	2002	957						13
14	Roof Repair	2002	5,283						14
15									15
16	Smoke Detectors and Installation	2003	5,970						16
17	Roof Replacement	2003	111,250						17
18	Sprinklers	2003	31,119						18
19	Parking Lot	2003	3,862						19
20	Ceramic Tile	2003	1,315						20
21	Compressor	2003	3,898						21
22	Wallpaper	2003	857						22
23	Maglock Keypad	2003	2,762						23
24	ANSUL Fire Surpression	2003	1,450						24
25	Fire Escape Remodel	2003	2,003						25
26	Adj to Capital Report	2003	(14,958)						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,379,180	\$ 424,499		\$ 424,499	\$	\$	34

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

Facility Name &amp; ID Number Heritage Health-Bloomington

# 0048157

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		\$ 3,379,180	\$ 424,499		\$ 424,499	\$	\$	1
2	Sewage Pump	2004	3,823						2
3	Nurses Station A/C	2004	1,478						3
4	Fire Alarm	2004	2,825						4
5	Sealcoat Parking Lot	2004	1,646						5
6	Storm Windows	2004	645						6
7	Window A/C (8)	2004	6,030						7
8	Ceiling Repairs	2004	4,011						8
9									9
10	Delayed Egress Latches	2005	12,431						10
11	Mixing valve	2005	1,360						11
12	Paint ceiling	2005	596						12
13	A/C	2005	2,153						13
14	Sidewalk	2005	2,100						14
15									15
16	Plumbing	2006	6,791						16
17	A/C -- Thru wall units	2006	6,900						17
18	Exterior Painting	2006	11,650						18
19	Compressor	2006	5,015						19
20	Condensing Unit	2006	4,902						20
21	Insinkerator	2006	2,350						21
22	Water Softener	2006	27,469						22
23	Basement De-watering	2006	3,750						23
24	Paint Kitchen	2006	1,820						24
25	Repair building	2006	1,199						25
26	Landscaping	2006	1,335						26
27	Pump Motor	2006	1,072						27
28	Mixing valve	2006	2,884						28
29	Adj to Capital Report	2006	(722)						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,494,693	\$ 424,499		\$ 424,499	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,494,693	\$ 424,499		\$ 424,499	\$	\$	1
2	Resident Rooms Remodel -- Paint and flooring	2007	13,957						2
3	Sprinkler	2007	1,152						3
4	Compressor	2007	4,006						4
5	Condensor	2007	2,250						5
6	Water Heater	2007	7,359						6
7	Therapy Room Remodel-- Paint & Flooring	2007	2,527						7
8	Window treatments	2007	583						8
9	Cooler	2007	642						9
10	Boiler	2007	4,803						10
11	Adj to Capital Report	2007	(8,178)						11
12	Heat/Cool Units	2008	5,420						12
13	Replace Fire Escape	2008	13,577						13
14	Schematic Design (Architect Fees) Facility Renovation	2008	26,038						14
15	Water Heater --Backflow	2008	4,926						15
16	Fire Alarm	2008	63,563						16
17	Water Heater	2008	6,057						17
18	Adj to Capital Report	2008	(19,981)						18
19	HVAC Unit	2009	7,035						19
20	Compressor	2009	4,658						20
21	HVAC Renovation: Boilers, ducts, hvac units & labor	2009	360,549						21
22	Windows	2009	148,790						22
23									23
24	HVAC Renovation: Boilers, ducts, hvac units & labor	2010	15,355						24
25	Architect, engineering fees	2010	87,978						25
26	trane compressor	2010	6,255						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,254,014	\$ 424,499		\$ 424,499	\$	\$	34

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

Facility Name &amp; ID Number Heritage Health-Bloomington

# 0048157

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 12D, Carried Forward		\$ 4,254,014	\$ 424,499		\$ 424,499	\$	\$	1
2									2
3	Signage	2011	9,969						3
4									4
5	PT Addition 2010 & 2011 - Contracted Total	2011	1,604,828						5
6	PT Addition 2010 & 2011 - Capitalized Interest	2011	7,278						6
7	Renovation 2010 & 2011 - Contracted Total	2011	2,381,723						7
8	Renovation 2010 & 2011 - Capitalized Interest	2011	15,565						8
9	Renovation 2010 & 2011 - Third Party Costs:								9
10	Architect	2011	44,486						10
11	Asbestos	2011	99,441						11
12	Construction Certificate Consultant	2011	6,150						12
13	Elevator	2011	4,000						13
14	Engineer	2011	9,238						14
15	Landscaping	2011	17,814						15
16	Legal/Plan Review	2011	12,720						16
17	Plumbing	2011	10,340						17
18	Signage, Electric,HVAC & Supplies	2011	4,352						18
19	Sitework	2011	3,795						19
20	Technology	2011	321,596						20
21	Window Coverings	2011	5,295						21
22									22
23	PT Addition (Additional Costs) - Signage	2012	2,213						23
24	Renovation (Additional Costs)								24
25	Architect	2012	749						25
26	Asbestos	2012	16,910						26
27	Landscaping	2012	70,935						27
28	Plumbing	2012	1,325						28
29	Signage, Electric,HVAC & Supplies	2012	6,275						29
30	Technology	2012	60,097						30
31	Window Coverings	2012	27,483						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,998,591	\$ 424,499		\$ 424,499	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 8,998,591	\$ 424,499		\$ 424,499	\$	\$	1
2									2
3	<b>Nurse Master Console</b>	2012	5,031						3
4									4
5	<b>Replacement- sprinkler heads, floor tile &amp; countertop-1 Rm.</b>	2013	10,395						5
6									6
7	<b>Elevator Power Unit Replacement</b>	2013	11,425						7
8	<b>Point of Care Kiosk Cabling</b>	2013	7,985						8
9	<b>Air conditioning units - new</b>	2013	3,646						9
10									10
11	<b>Final Charge - Elevator Power Replacement</b>	2014	8,275						11
12	<b>Install 9 PTAC Units</b>	2014	3,834						12
13	<b>Elevator Upgrades-Code Requirements</b>	2014	10,153						13
14	<b>Install Split Replacement Systems - Rooms 129 and 130</b>	2014	18,566						14
15	<b>Parking Lot Upgrades</b>	2014	10,025						15
16	<b>Replace Sewage Ejection Pump</b>	2014	6,146						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,094,072	\$ 424,499		\$ 424,499	\$	\$	34

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

Facility Name & ID Number Heritage Health-Bloomington

# 0048157

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	\$ 2,193,145	\$ 163,093	\$ 163,093	\$		\$	71
72	Current Year Purchases	54,084						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,247,229	\$ 163,093	\$ 163,093	\$		\$	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)	\$ 11,596,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 587,592	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 587,592	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	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: \$ 20,337 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.

Facility Name & ID Number Heritage Health-Bloomington # 0048157 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<p><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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 318,419	\$		\$ 318,419	1
2	Licensed Speech and Language Development Therapist		hrs			82,795			82,795	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			349,464	229		349,693	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				742,843		742,843	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					54,350			54,350	13
14	<b>TOTAL</b>			\$		\$ 805,028	\$ 743,072		\$ 1,548,100	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-Bloomington

# 0048157

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 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	18,278		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,024,466		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,294		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,342,846)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (1,271,408)	\$	10
<b>B. Long-Term Assets</b>				
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (1,271,408)	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 305,076	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,278		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	217,232		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,587		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>Bed Tax</u>	56,281		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 602,454	\$	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>	\$ 602,454	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,873,862)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (1,271,408)	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (2,098,987)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (2,098,987)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	225,125	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 225,125	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,873,862)	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	\$ 6,277,211	1
2	Discounts and Allowances for all Levels	(3,221,493)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,055,718</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,680,645	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,680,645</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	420	12
13	Barber and Beauty Care	1,252	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,500	16
17	Sale of Drugs	1,336,582	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,345,754</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	18,038	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 18,038</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		5,000	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,000</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,105,155</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,029,036	31
32	Health Care	3,800,269	32
33	General Administration	1,525,646	33
<b>B. Capital Expense</b>			
34	Ownership	525,079	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>\$ 6,880,030</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>225,125</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 225,125</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 Heritage Health-Bloomington

# 0048157

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	1,805	1,984	\$ 63,234	\$ 31.87	1
2	Assistant Director of Nursing	1,837	2,019	82,700	40.96	2
3	Registered Nurses	20,630	22,183	589,449	26.57	3
4	Licensed Practical Nurses	16,058	17,267	393,521	22.79	4
5	CNAs & Orderlies	55,770	59,968	752,107	12.54	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	376	404	9,863	24.41	8
9	Activity Director					9
10	Activity Assistants	4,866	5,232	62,338	11.91	10
11	Social Service Workers	3,756	4,039	65,685	16.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,557	22,104	265,987	12.03	15
16	Dishwashers					16
17	Maintenance Workers	5,580	6,000	92,548	15.42	17
18	Housekeepers	8,225	8,844	93,785	10.60	18
19	Laundry	5,541	5,958	67,728	11.37	19
20	Administrator	1,900	2,080	80,184	38.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,137	7,674	178,690	23.29	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)	154,038	165,756	\$ 2,797,819 *	\$ 16.88	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	15,828		36
37	Medical Records Consultant	10,665		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,660		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	465		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 33,618		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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Bloomington# 0048157

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. \$ 60,773  
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. \$ 5,680
- (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	400						1,009	1,009 PETTY CASH 400
1010	CASH IN BANK							1,100	1,100 ACCTS R 1,024,466
1040	CASH IN BANK-PAYROLL							1,101	1,101 ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	1,024,466						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 28,294
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	28,294						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 18,278
1490	ACCUM DEPR-BUILDING	0						1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	18,278						1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850 INTERCO (2,342,846)
1560	REAL ESTATE TAX ESCROW							2,010	2,010 ACCOUN (305,076)
1575	REIMBURSABLE PURCHASES							2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-2,342,846						2,100	2,100 ACCRUEI (92,406)
2010	ACCOUNTS PAYABLE	-305,076						2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-92,406						2,110	2,110 ACCRUEI (124,826)
2110	ACCRUED VACATION PAY	-124,826						2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(5,587)	
2125	FICA TAX PAYABLE	-5,587	-5,587	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 REFU		
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 - CAFETER		
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 GA		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUEI	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(56,281)	
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-56,281		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(18,278)	
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 DEB		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	2,098,987	
2460	INCOME TAXES PAYABLE					net income	(225,125)
2512	DUE TO RESIDENTS	-18,278					
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	2,098,987					
2970	PROFIT/LOSS FOR PERIOD	-225,125					
3007.1	PATIENT DAYS-PRIVATE	10,039					3,007

3007.2	PATIENT DAYS-IPA	10,770						3,007
3007.3	PATIENT DAYS-MEDICARE	5,054						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	-6,256,648	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	-17,459	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	-1,336,582	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,680,645	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	3,221,493	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	-7,500		6	0	6	-7,500		3,530
3530	13 BEAUTY SHOP	-1,252		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-420		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-3,104		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	167,157	178,690	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	80,184	80,184	17	1	0	0		4,120
4115	VACATION & SICK - G&A	11,533		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	27,981	622,117	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	25,504		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP COST	14,420		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255 OFFICE SUPPLIES	27,962	27,962	21	2	0	0		4,275
4260	TELEPHONE	27,383	27,383	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	8,069	8,069	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	5,919	7,815	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	130		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,766		24	3	19	-11,705 ***		4,289
4290	HELP WANTED ADVERTISING	8,857	179,841	20	3	0	0 -60,773		4,290
4291	PROMOTIONAL ADVERTISING	71,756		20	3	25	-71,756		4,291
4292	PUBLIC RELATIONS	19,827		20	3	25	-19,827		4,292
4300	LICENSES & FEES	66,484		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	7,670		20	3	17	-3,946		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	13,026	315,786	19	3	22	-4,532		4,350
4355	MEDICAL DIRECTOR	15,828	15,828	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	10,665		10	3	0	0	4,364
4363	PHARMACIST FEES	6,660		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	465	465	12	3	0	0	4,383
4370	TV RENTAL	10,478		35	3	5	0	4,390
4380	INCOME TAXES		0	27	3	26	0	4,400
4383	BACKGROUND CHECKS	5,247		20	3	26	0	4,401
4400	PAYROLL TAXES	253,483		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	8,323		22	3	0	0	4,420
4410	GROUP INSURANCE	242,920		22	3	0	0	4,430
4420	LIABILITY INSURANCE	77,799	77,799	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	49,486		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	302,760		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	0		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	9,859	20,337	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	84,986	92,548	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	7,562		6	1	0	0	4,510
5130	ELECTRIC	46,281	113,262	5	3	0	0	4,600
5131	NATURAL GAS	40,551		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	26,430		5	3	0	0	5,130
5134	TRASH COLLECTION	14,501	83,830	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	12,176	48,954	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	36,778		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	69,329		6	3	0	0	5,140
5210	DIETARY WAGES	245,984	265,987	1	1	0	0	5,160
5220	DIETARY SICK & VAC	20,003		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	198,975	193,295	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,954	22,469	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	6,370		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	13,145		1	2	0	0	5,260
5295	MEAL CREDIT	-5,680		2	2	0	0	5,270
5310	LAUNDRY WAGES	62,458	67,728	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	5,270		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	11,055	15,659	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	4,604		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	87,962	93,785	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	5,823		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	28,378	31,519	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	3,141		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,890,874	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	540,118		10	1	0	0	6,020
6030	DON WAGES	63,234		10	1	0	0	6,030
6035	ADON	82,700		10	1	0	0	6,035
6040	RN SICK & VACATION	49,331		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	365,219		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	28,302		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	712,578		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	39,529		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	11,386		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	9,238		10	1	0	0	6,390
6275	REHAB SICK & VAC	625		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	173,379	182,054	10	2	0	0	7,281
6295	NURSING SUPPLIES	7,706		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	969		10	2	0	0	7,391
6490	NURSING OTHER	3,787	32,498	10	3	0	0	7,393
7280	DRUG PURCHASES	446,037	743,072	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	296,806		39	2			7,540
7380	LABORATORY SERVICES	54,350	805,028	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	57,530	62,338	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,808		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	2,427	2,427	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	349,464		39	3	0	0 ***	7,890
7660	PT SUPPLIES	229		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	61,850	65,685	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	3,835		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	318,419		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	82,795		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	486,180	486,180	34	3	0	0	

8120	INTEREST EXPENSE	18,562	18,562	32	3	14	-18,038	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-18,038		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	-5,000		0	0	0	0	

6,856,992 6,880,030  
23,038

GRAND TOTALS

-225,125 -137,304  
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	10,039	10,039
IPA	10,770	10,770
medic	5,054	5,054
		25,863

S

JND

IA

T

T

3,007 PATIENT	10,770
3,007 PATIENT	5,054
	0
3,010 BASIC CI	(6,256,648)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(17,459)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(1,336,582)
	0
3,110 PHYSICIAN	(2,680,645)
	0
3,112 PHYSICIAN	0
3,113 PHYSICIAN	0
3,140 LABORATORY INCOME	
	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	3,179,840

3,520 RENT INC	(7,500)
3,530 BEAUTY	(1,252)
	0
3,570 VENDING	(420)
3,590 EQUIPMI	(3,104)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	167,157
4,111 ADMINIS	80,184
4,115 G&A PTC	11,533
4,120 EMPLOY	27,196
4,130 EMPLOY	25,504
4,135 EMPLOY	14,420
4,250 OFFICE S	14,981
4,255 POSTAGI	4,941
4,260 TELEPHC	27,383
4,275 TRAININ	8,069
	0
4,280 GENERA	5,919
4,281 MEAL EX	130
4,285 EDUCAT	1,703
4,289 MEETING	63
4,290 HELP WA	8,857
4,291 PROMOT	71,756
4,292 PUBLIC I	19,827
4,300 LICENSE	66,484
4,310 DUES & S	7,670
4,320 CONTRIB	0
4,350 PROFESS	13,026
4,355 MEDICAL	15,828
	10,665
	6,660

4,364 SOCIAL S	465
4,370 TV RENT	10,478
4,383 BACKGR	5,247
4,390 OTHER T	(5,000)
4,400 PAYROL	253,483
4,401 PAYROL	8,323
4,410 GROUP I	242,920
4,420 LIABILIT	77,799
4,430 WORKM	47,818
4,435 W/C-FIRS	30
4,436 DRUG TE	1,638
4,450 MANAGI	302,760
4,460 BAD DEF	0
4,461 BAD DEF	41,653
4,470 LOST ITE	0
4,475 UNIFORM	785
4,486 SERVICE	31,276
4,490 MISC EX	154
4,496 MISC. M.	8,040
4,510 REAL ES	0
4,600 LEASED	9,859
5,110 MAINTEI	84,986
5,120 MAINTEI	7,562
5,130 ELECTRI	46,281
5,131 NATURA	40,551
5,133 WATER &	26,430
5,134 TRASH C	14,501
5,140 PROP/PL	12,176
5,160 GENERA	36,778
5,165 MAINTEI	38,053
5,210 DIETARY	245,984
5,220 DIETARY	20,003
5,248 FOOD PU	198,821

5,250 SUPPLIE	2,954
5,260 REPLACI	6,370
5,270 KITCHEN	13,145
5,295 MEAL IN	(5,680)
5,310 LAUNDR	62,458
5,340 LAUNDR	5,270
5,370 REPLACI	11,055
	0
5,390 SUPPLIE	4,604
5,410 HOUSEK	87,962
5,440 HOUSEK	5,823
5,480 SUPPLIE	28,378
5,490 SUPPLIE	3,141
6,020 RN WAG	540,118
6,030 DON WA	63,234
6,035 ADON W	82,700
6,040 RN PTO &	49,331
6,120 LPN WAG	365,219
6,140 LPN PTO	28,302
6,220 AIDES W	712,578
6,240 AIDES PT	39,529
6,245	11,386
	0
	0
	0
6,270 REHAB V	9,238
6,275 REHAB F	625
6,290 NURSINC	173,379
6,295 NURSINC	7,706
6,390 REPLACI	969
6,490 OTHER	3,787

7,280 DRUG PU	446,037
7,281 DRUG PU	296,806
7,380 LABORA	0
7,390 X-RAY S	54,350
	0
7,510 ACTIVIT	57,530
7,540 ACTIVIT	4,808
7,590 ACTIVIT	2,427
7,620 PHYSICA	349,464
7,660 P.T. SUPE	229
7,710 SOCIAL S	61,850
7,720 SOCIAL S	3,835
7,730 SOCIAL S	0
7,740 OCCUPA	318,419
7,770 SPEECH '	82,795
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	0
	18,562
8,130 DEPRECI	0
	0
9,510 INTERES	(18,038)
9,520 MISC NO	0
4,220	0
8,100	486,180
9,702	0
5,230	0
	<u>(225,125)</u>

Expenses Fixed Assets

