

Facility Name & ID Number Heritage Health-Elgin

0048132 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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	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	23,416	3,185	2,590	29,191	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,416	3,185	2,590	29,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.08%

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 2,590

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-Elgin

0048132

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	260,570	23,051		283,621		283,621	4,737	288,358		1
2	Food Purchase		211,838		211,838		211,838	56	211,894		2
3	Housekeeping	90,191	35,382		125,573		125,573		125,573		3
4	Laundry	47,988	15,347		63,335		63,335		63,335		4
5	Heat and Other Utilities			104,421	104,421		104,421	1,292	105,713		5
6	Maintenance	116,396	75,202	53,846	245,444		245,444	16,139	261,583		6
7	Other (specify):*										7
8	TOTAL General Services	515,145	360,820	158,267	1,034,232		1,034,232	22,224	1,056,456		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,938,822	100,900	31,320	2,071,042		2,071,042	275	2,071,317		10
10a	Therapy		417,755	582,212	999,967	(416,700)	583,267		583,267		10a
11	Activities	62,345	7,667		70,012		70,012		70,012		11
12	Social Services	38,242		3,681	41,923		41,923		41,923		12
13	CNA Training		1,950		1,950		1,950	797	2,747		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,039,409	528,272	629,213	3,196,894	(416,700)	2,780,194	1,072	2,781,266		16
	C. General Administration										
17	Administrative	106,774			106,774		106,774		106,774		17
18	Directors Fees										18
19	Professional Services			304,321	304,321		304,321	(284,331)	19,990		19
20	Dues, Fees, Subscriptions & Promotions			94,384	94,384	(51,465)	42,919	(23,462)	19,457		20
21	Clerical & General Office Expenses	255,410	34,711	25,238	315,359		315,359	290,529	605,888		21
22	Employee Benefits & Payroll Taxes			562,144	562,144		562,144	47,818	609,962		22
23	Inservice Training & Education			7,796	7,796		7,796	1,420	9,216		23
24	Travel and Seminar			5,748	5,748		5,748	(749)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			74,000	74,000		74,000	10,704	84,704		26
27	Other (specify):*			5,000	5,000		5,000	(5,000)			27
28	TOTAL General Administration	362,184	34,711	1,078,631	1,475,526	(51,465)	1,424,061	36,929	1,460,990		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,916,738	923,803	1,866,111	5,706,652	(468,165)	5,238,487	60,225	5,298,712		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.

Facility Name & ID Number

Heritage Health-Elgin

#0048132

Report Period Beginning:

01/01/14

Ending:

12/31/14

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							148,127	148,127			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,606	19,606		19,606	12,603	32,209			32
33	Real Estate Taxes							41,653	41,653			33
34	Rent-Facility & Grounds			411,720	411,720		411,720	(405,747)	5,973			34
35	Rent-Equipment & Vehicles			26,026	26,026		26,026	7,556	33,582			35
36	Other (specify):*											36
37	TOTAL Ownership			457,352	457,352		457,352	(195,808)	261,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					416,700	416,700	5,054	421,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					468,165	468,165	5,054	473,219			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,916,738	923,803	2,323,463	6,164,004		6,164,004	(130,529)	6,033,475			45

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

Facility Name & ID Number Heritage Health-Elgin

0048132

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				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	(17,914)			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	(2,710)			17
18	Fines and Penalties				18
19	Entertainment	(8,277)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(30,083)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,000)			24
25	Fund Raising, Advertising and Promotional	(28,412)			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)	\$ (92,396)		\$	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)	(38,133)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,133)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (130,529)		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-Elgin

ID# 0048132

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		(2,710)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(30,083)	19	22
23				23
24		(5,000)	27	24
25		(28,412)	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		(66,205)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Elgin# 0048132

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	4,737	0	0	0	0	0	0	0	0	4,737	1
2	Food Purchase	0	0	56	0	0	0	0	0	0	0	0	56	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	1,292	0	0	0	0	0	0	0	0	1,292	5
6	Maintenance	0	0	16,139	0	0	0	0	0	0	0	0	16,139	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,224	0	22,224	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	275	0	0	0	0	0	0	0	0	275	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	797	0	0	0	0	0	0	0	0	797	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	1,072	0	1,072	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	(30,083)	(273,312)	19,064	0	0	0	0	0	0	0	0	(284,331)	19
20	Fees, Subscriptions & Promotions	(31,122)	0	7,660	0	0	0	0	0	0	0	0	(23,462)	20
21	Clerical & General Office Expenses	0	0	290,529	0	0	0	0	0	0	0	0	290,529	21
22	Employee Benefits & Payroll Taxes	0	0	47,818	0	0	0	0	0	0	0	0	47,818	22
23	Inservice Training & Education	0	0	1,420	0	0	0	0	0	0	0	0	1,420	23
24	Travel and Seminar	(8,277)	0	7,528	0	0	0	0	0	0	0	0	(749)	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	10,704	0	0	0	0	0	0	0	0	10,704	26
27	Other (specify):*	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	27
28	TOTAL General Administration	(74,482)	(273,312)	384,723	0	36,929	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,482)	(273,312)	408,019	0	60,225	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Elgin# 0048132

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	129,138	0	18,989	0	0	0	0	0	0	0	148,127	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,914)	30,541	0	(24)	0	0	0	0	0	0	0	12,603	32
33	Real Estate Taxes	0	41,653	0	0	0	0	0	0	0	0	0	41,653	33
34	Rent-Facility & Grounds	0	(411,720)	0	5,973	0	0	0	0	0	0	0	(405,747)	34
35	Rent-Equipment & Vehicles	0	0	0	7,556	0	0	0	0	0	0	0	7,556	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,914)	(210,388)	0	32,494	0	(195,808)	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	5,054	0	0	0	0	0	0	0	0	0	5,054	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	5,054	0	0	0	0	0	0	0	0	0	5,054	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(92,396)	(478,646)	408,019	32,494	0	(130,529)	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>Attachment-See Following Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt Svcs</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>5,054</u>	<u>5,054</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>273,312</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(273,312)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>411,720</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(411,720)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>41,653</u>	<u>41,653</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>25,768</u>	<u>25,768</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>129,138</u>	<u>129,138</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		\$ 685,032			\$ 206,386	\$ * (478,646)	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.		\$	\$	4,737	15	
16	V	2 Food Purchase						56	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						1,292	19	
20	V	6 Maintenance						16,139	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						275	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						797	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						19,064	31	
32	V	20 Fees, Subscription, Promotions						7,660	32	
33	V	21 Clerical & General Office Expenses						290,529	33	
34	V	22 Employee Benefits & Payroll Taxes						47,818	34	
35	V	23 Inservice Training & Education						1,420	35	
36	V	24 Travel and Seminar						7,528	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						10,704	38	
39	Total		\$			\$	0	\$ *	408,019	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						18,989	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(24)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						5,973	20	
21	V	35 Rent-Equipment & Vehicles						7,556	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	\$ *	32,494	39

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

Facility Name & ID Number Heritage Health-Elgin # 0048132 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-Elgin

0048132

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	94	\$ 4,737	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	94	56	2
3	3	Housekeeping	Beds	2,666	25	0	0	94	0	3
4	4	Laundry	Beds	2,666	25	0	0	94	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	94	1,292	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	94	16,139	6
7	7	Other	Beds	2,666	25	0	0	94	0	7
8	9	Medical Director	Beds	2,666	25	0	0	94	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	94	275	9
10	11	Activities	Beds	2,666	25	0	0	94	0	10
11	12	Social Service	Beds	2,666	25	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	94	797	12
13	14	Program Transportation	Beds	2,666	25	0	0	94	0	13
14	15	Other	Beds	2,666	25	0	0	94	0	14
15	17	Administrative	Beds	2,666	25	0	0	94	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	94	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	94	19,064	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	94	7,660	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	94	290,529	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	94	47,818	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	94	1,420	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	94	7,528	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	94	10,704	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 408,019	25

Facility Name & ID Number Heritage Health-Elgin

0048132

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	\$	94	\$	1
2	30	Depreciation	Beds	2,666	25	538,548	94	18,989	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25		94		3
4	32	Interest	Beds	2,666	25	(682)	94	(24)	4
5	33	Real Estate Taxes	Beds	2,666	25		94		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393	94	5,973	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306	94	7,556	7
8	36	Other	Beds	2,666	25		94		8
9	38	Medically Nec Transportation	Beds	2,666	25		94		9
10	39	Ancillary Service Centers	Beds	2,666	25		94		10
11	40	Barber and Beauty Shops	Beds	2,666	25		94		11
12	41	Coffee and Gift Shops	Beds	2,666	25		94		12
13	42	Other	Beds	2,666	25		94		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	\$		\$ 32,494	25

Facility Name & ID Number

Heritage Health-Elgin

0048132

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					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			\$	\$			\$ 25,768						
2	Bank of America		x	Loan Fee Amortization							4,773						
3																	
4																	
5																	
Working Capital																	
6	Bank of America		x	Working Capital							19,606						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 50,147						
B. Non-Facility Related*																	
10	Interest Income										(17,914)						
11																	
12	Allocated Corporate										(24)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (17,938)						
15	TOTALS (line 9+line14)						\$	\$			\$ 32,209						

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.)		\$	41,653		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	41,653		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.		\$	41,653		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;">FOR BHF USE ONLY</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>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	_____	9																
	2011	45,693	10																
	2012	45,145	11																
	2013	41,653	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-Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0048132

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>0624201003</u>	_____	\$ 39,344.96	\$ 39,344.96
2. <u>0624201002</u>	_____	\$ 1,312.98	\$ 1,312.98
3. <u>0624201004</u>	_____	\$ 995.48	\$ 995.48
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>41,653.42</u>	\$ <u>41,653.42</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-Elgin

0048132 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,804 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				\$ <u>80,000</u>	1
2					2
3	TOTALS			\$ <u>80,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	94			\$ 720,000	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	1989 Improvements	1989		180,739					9
10	1990 Improvements	1990		658,346					10
11	1990 Improvements	1990		4,320					11
12	1991 Improvements	1991		52,989					12
13	1992 Improvements	1992		6,777					13
14	1993 Improvements	1993		54,564					14
15	1994 Improvements	1994		81,347					15
16	1995 Improvements	1995		146,394					16
17	Remodel Resident Day Room/Nurses Station	1996		23,749					17
18	Interior Rehab	1997		751					18
19	Electric Water Heater	1997		3,965					19
20	Booster Heater	1997		1,622					20
21	Water Heater and Storage Tank	1998		6,485					21
22									22
23	Water Heater	1999		4,750					23
24	Code Alert System	1999		1,570					24
25	Resident Room Remodel--Material and Labor	1999		2,571					25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	C/O Allocation				18,989		18,989		33
34	Book Depreciation				108,419		108,419		34
35									35
36									36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	South Wing Remodel -- Labor / Materials	2000	\$ 14,334	\$		\$	\$	\$	37
38	Door	2000	1,535						38
39	Dry Chemical Extinguisher	2000	1,746						39
40									40
41	Water Heater	2001	4,935						41
42	Valve thermometer	2001	4,520						42
43	A/C Unit	2001	3,319						43
44	Hallway Carpet and Tile Material and Labor	2001	28,843						44
45	Wallpaper	2001	2,390						45
46	Nurse Call System	2001	21,612						46
47									47
48	Hallway and Room Carpet and Tile Material	2002	74,533						48
49	Labor	2002	68,734						49
50	Professional Fees	2002	16,497						50
51	Kitchen Pipe	2002	1,830						51
52	Shower Repairs	2002	5,063						52
53	A/C Unit	2002	5,864						53
54	Bathroom Rehab	2002	750						54
55	Condensor	2002	1,600						55
56	Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57									57
58	Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59	Exterior Door	2003	320						59
60	Parking Lot Sealer	2003	4,469						60
61	Door Security	2003	2,160						61
62	Ductwork	2003	6,628						62
63	compressor	2003	1,195						63
64	Blower Unit	2003	1,784						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,324,370	\$ 127,408		\$ 127,408	\$	\$	70

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

Facility Name & ID Number Heritage Health-Elgin

0048132

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 12A, Carried Forward		\$ 2,324,370	\$ 127,408		\$ 127,408	\$	\$	1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7	Fire Alarm	2006	1,714						7
8	Parking Lot	2006	2,344						8
9	Remodel Corridor --paint	2006	4,028						9
10	Water Main	2006	3,250						10
11									11
12	Roof	2007	94,451						12
13	Central Corridor paint, tile	2007	49,685						13
14	Plumbing fixtures	2007	2,400						14
15	Rooftop heat/cool unit	2007	5,565						15
16									16
17	A/C Units	2008	19,600						17
18	4 Ton A/C Unit	2008	2,600						18
19	HVAC Rooftop Unit	2008	11,000						19
20									20
21	Patio	2009	11,693						21
22	Front Entry Doors	2009	13,529						22
23	Front Office Carpet and Window Treatments	2009	3,864						23
24									24
25	Cat5 cable/wire facility	2010	6,607						25
26									26
27	Electric water heater	2011	11,750						27
28	Sign	2011	2,500						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,576,726	\$ 127,408		\$ 127,408	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,576,726	\$ 127,408		\$ 127,408	\$	\$	1
2									2
3	Smoke Detector	2012	6,090						3
4	Aiphone	2012	7,030						4
5	Walk in Freezer	2012	5,210						5
6									6
7	Fire Sprinler System	2013	167,700						7
8	Lighting Retrofit	2013	13,876						8
9	New 60 kw Generator	2013	75,234						9
10	Install Door Alarms	2013	5,252						10
11	Fire Alarm Control Panel	2013	12,311						11
12	Parking Lot Replacement	2013	72,770						12
13	Cabling for Wireless Network	2013	11,960						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,954,159	\$ 127,408		\$ 127,408	\$	\$	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	\$ 796,724	\$ 20,719	\$ 20,719	\$		\$	71
72	Current Year Purchases	4,589						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 801,313	\$ 20,719	\$ 20,719	\$		\$	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)	\$ 3,835,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 148,127	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,127	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: \$ 26,026 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,950		1,950
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	\$	\$ 1,950	\$	\$ 1,950
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,950		

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	\$		\$	247,341	\$		\$	247,341	1
2	Licensed Speech and Language Development Therapist		hrs				49,706				49,706	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				279,223		6,997		286,220	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						410,758		410,758	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						5,942				5,942	13
14	TOTAL			\$		\$	582,212	\$	417,755	\$	999,967	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-Elgin

0048132

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	\$ 800	\$	1
2	Cash-Patient Deposits	53,002		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,013,442		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,873		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(108,714)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 989,403	\$	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)	\$ 989,403	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 238,959	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,002		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	347,278		30
31	Accrued Taxes Payable (excluding real estate taxes)	(28,512)		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>	70,618		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 681,345	\$	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)	\$ 681,345	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 308,058	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 989,403	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 172,836	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 172,836	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	135,222	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)	\$ 135,222	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)	\$ 308,058	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	\$ 5,550,443	1
2	Discounts and Allowances for all Levels	(1,814,355)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,736,088	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,804,330	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,804,330	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	740,894	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 740,894	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,914	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,914	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,299,226	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,034,232	31
32	Health Care	3,196,894	32
33	General Administration	1,475,526	33
B. Capital Expense			
34	Ownership	457,352	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)*	\$ 6,164,004	40
41	Income before Income Taxes (line 30 minus line 40)**	135,222	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 135,222	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-Elgin

0048132

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	1,830	1,968	\$ 86,510	\$ 43.96	1
2	Assistant Director of Nursing	3,559	3,827	153,827	40.20	2
3	Registered Nurses	15,539	16,709	545,662	32.66	3
4	Licensed Practical Nurses	7,088	7,622	196,703	25.81	4
5	CNAs & Orderlies	56,399	60,644	898,949	14.82	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,957	3,180	57,171	17.98	8
9	Activity Director					9
10	Activity Assistants	5,526	5,942	62,345	10.49	10
11	Social Service Workers	1,824	1,961	38,242	19.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,530	21,000	260,570	12.41	15
16	Dishwashers					16
17	Maintenance Workers	5,675	6,102	116,396	19.08	17
18	Housekeepers	9,453	10,164	90,191	8.87	18
19	Laundry	3,615	3,887	47,988	12.35	19
20	Administrator	1,872	2,080	106,774	51.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,830	10,570	255,410	24.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,697	155,656	\$ 2,916,738 *	\$ 18.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,531		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,640		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	3,681		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,852		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-Elgin

0048132

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. \$ 51,465
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. \$ 0
- (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	800						1,009	1,009 PETTY CASH 800
1010	CASH IN BANK							1,100	1,100 ACCTS R 1,013,442
1040	CASH IN BANK-PAYROLL							1,101	1,101 ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	1,013,442						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 30,873
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	30,873						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	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 53,002
1490	ACCUM DEPR-BUILDING	0						1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	53,002						1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850 INTERCO (108,714)
1560	REAL ESTATE TAX ESCROW							2,010	2,010 ACCOUN (238,959)
1575	REIMBURSABLE PURCHASES							2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-108,714						2,100	2,100 ACCRUEI (149,632)
2010	ACCOUNTS PAYABLE	-238,959						2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-149,632						2,110	2,110 ACCRUEI (197,646)
2110	ACCRUED VACATION PAY	-197,646						2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	28,512
2125	FICA TAX PAYABLE	28,512	28,512	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	(70,618)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-70,618		2,400	2,400 CURRENT PORTION OF LT DEB	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(53,002)
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	(172,836)
2460	INCOME TAXES PAYABLE				net income	(135,222)
2512	DUE TO RESIDENTS	-53,002				
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	-172,836				
2970	PROFIT/LOSS FOR PERIOD	-135,222				
3007.1	PATIENT DAYS-PRIVATE	3,185				3,007

3007.2	PATIENT DAYS-IPA	23,416						3,007
3007.3	PATIENT DAYS-MEDICARE	2,590						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	-5,531,868	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	-15,209	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	-740,894	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,804,330	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	1,814,355	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	0		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-3,366		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	240,313	255,410	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	106,774	106,774	17	1	0	0		4,120
4115	VACATION & SICK - G&A	15,097		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	15,857	562,144	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP COST	0		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	34,711	34,711	21	2	0	0		4,275
4260	TELEPHONE	25,238	25,238	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	7,796	7,796	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	4,296	5,748	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	74		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,378		24	3	19	-8,277 ***		4,289
4290	HELP WANTED ADVERTISING	3,343	94,384	20	3	0	0 -51,465		4,290
4291	PROMOTIONAL ADVERTISING	6,544		20	3	25	-6,544		4,291
4292	PUBLIC RELATIONS	21,868		20	3	25	-21,868		4,292
4300	LICENSES & FEES	56,301		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	4,847		20	3	17	-2,710		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	31,009	304,321	19	3	22	-30,083		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSULT	1,531		10	3	0	0	4,364
4363	PHARMACIST FEES	5,640		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,681	3,681	12	3	0	0	4,383
4370	TV RENTAL	24,644		35	3	5	0	4,390
4380	INCOME TAXES		5,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,481		20	3	26	0	4,401
4400	PAYROLL TAXES	247,969		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	11,083		22	3	0	0	4,420
4410	GROUP INSURANCE	263,610		22	3	0	0	4,430
4420	LIABILITY INSURANCE	74,000	74,000	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	23,625		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	273,312		19	3	34	0 **	4,460
4460	BAD DEBTS	5,000		27	3	24	-5,000	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	1,382	26,026	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	107,993	116,396	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	8,403		6	1	0	0	4,510
5130	ELECTRIC	72,112	104,421	5	3	0	0	4,600
5131	NATURAL GAS	6,399		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	25,910		5	3	0	0	5,130
5134	TRASH COLLECTION	11,566	53,846	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	9,356	75,202	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	65,846		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	42,280		6	3	0	0	5,140
5210	DIETARY WAGES	242,993	260,570	1	1	0	0	5,160
5220	DIETARY SICK & VAC	17,577		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	211,838	211,838	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,493	23,051	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	8,027		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	12,531		1	2	0	0	5,260
5295	MEAL CREDIT	0		2	2	0	0	5,270
5310	LAUNDRY WAGES	44,310	47,988	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,678		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	10,293	15,347	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,054		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	86,552	90,191	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	3,639		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	30,310	35,382	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	5,072		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,938,822	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	486,675		10	1	0	0	6,020
6030	DON WAGES	86,510		10	1	0	0	6,030
6035	ADON	153,827		10	1	0	0	6,035
6040	RN SICK & VACATION	58,987		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	184,956		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	11,747		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	842,404		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	56,545		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	1,950	1,950	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	55,005		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,166		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	47,280	100,900	10	2	0	0	7,281
6295	NURSING SUPPLIES	37,183		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	16,437		10	2	0	0	7,391
6490	NURSING OTHER	24,149	31,320	10	3	0	0	7,393
7280	DRUG PURCHASES	123,208	417,755	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	287,550		39	2			7,540
7380	LABORATORY SERVICES	5,942	582,212	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	61,271	62,345	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	1,074		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	7,667	7,667	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	279,223		39	3	0	0 ***	7,890
7660	PT SUPPLIES	6,997		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	35,218	38,242	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	3,024		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	247,341		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	49,706		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	411,720	411,720	34	3	0	0	

8120	INTEREST EXPENSE	19,606	19,606	32	3	14	-17,914	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-17,914		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

6,146,090 6,164,004
17,914

GRAND TOTALS -135,222 -92,396
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	3,185	3,185
IPA	23,416	23,416
medic	2,590	2,590
		29,191

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3,007 PATIENT	23,416
3,007 PATIENT	2,590
	0
3,010 BASIC CI	(5,531,868)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(15,209)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(740,894)
	0
3,110 PHYSICIA	(1,804,330)
	0
3,112 PHYSICIA	0
3,113 PHYSICIA	0
3,140 LABORATORY INCOME	
	0
3,152 ST/OT TF	0
3,153 ST/OT TF	0
3,185 REHAB/ISOLATION/OTHER CHG	
3,410 IPA/OTH	0
3,411 MEDICAL	0
3,420 MEDICAL	1,664,802

3,520 RENT INC	0
3,530 BEAUTY	0
	0
3,570 VENDING	0
3,590 EQUIPMI	(3,366)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	240,313
4,111 ADMINIS	106,774
4,115 G&A PTC	15,097
4,120 EMPLOY	15,113
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	19,029
4,255 POSTAGI	7,032
4,260 TELEPHC	25,238
4,275 TRAININ	7,796
	0
4,280 GENERA	4,296
4,281 MEAL EX	74
4,285 EDUCAT	1,378
4,289 MEETING	0
4,290 HELP WA	3,343
4,291 PROMOT	6,544
4,292 PUBLIC I	21,868
4,300 LICENSE	56,301
4,310 DUES & S	4,847
4,320 CONTRIB	0
4,350 PROFESS	31,009
4,355 MEDICAL	12,000
	1,531
	5,640

4,364 SOCIAL S	3,681
4,370 TV RENT	24,644
4,383 BACKGR	1,481
4,390 OTHER T	0
4,400 PAYROL	247,969
4,401 PAYROL	11,083
4,410 GROUP I	263,610
4,420 LIABILIT	74,000
4,430 WORKM	23,035
4,435 W/C-FIRS	0
4,436 DRUG TE	590
4,450 MANAGI	273,312
4,460 BAD DEF	5,000
4,461 BAD DEF	149,553
4,470 LOST ITE	0
4,475 UNIFORM	744
4,486 SERVICE	19,231
4,490 MISC EX	22
4,496 MISC. M.	8,650
4,510 REAL ES	0
4,600 LEASED	1,382
5,110 MAINTEI	107,993
5,120 MAINTEI	8,403
5,130 ELECTRI	72,112
5,131 NATURA	6,399
5,133 WATER &	25,910
5,134 TRASH C	11,566
5,140 PROP/PL	9,356
5,160 GENERA	65,846
5,165 MAINTEI	23,049
5,210 DIETARY	242,993
5,220 DIETARY	17,577
5,248 FOOD PU	211,816

5,250 SUPPLIE	2,493
5,260 REPLACI	8,027
5,270 KITCHEN	12,531
5,295 MEAL IN	0
5,310 LAUNDR	44,310
5,340 LAUNDR	3,678
5,370 REPLACI	10,293
	0
5,390 SUPPLIE	5,054
5,410 HOUSEK	86,552
5,440 HOUSEK	3,639
5,480 SUPPLIE	30,310
5,490 SUPPLIE	5,072
6,020 RN WAG	486,675
6,030 DON WA	86,510
6,035 ADON W	153,827
6,040 RN PTO &	58,987
6,120 LPN WAG	184,956
6,140 LPN PTO	11,747
6,220 AIDES W	842,404
6,240 AIDES PT	56,545
6,245	0
	0
	1,950
	0
6,270 REHAB V	55,005
6,275 REHAB F	2,166
6,290 NURSINC	47,280
6,295 NURSINC	37,183
6,390 REPLACI	16,437
6,490 OTHER	24,149

7,280 DRUG PU	123,208
7,281 DRUG PU	287,550
7,380 LABORA	2,798
7,390 X-RAY S	3,144
	0
7,510 ACTIVIT	61,271
7,540 ACTIVIT	1,074
7,590 ACTIVIT	7,667
7,620 PHYSICA	279,223
7,660 P.T. SUPE	6,997
7,710 SOCIAL S	35,218
7,720 SOCIAL S	3,024
7,730 SOCIAL S	0
7,740 OCCUPA	247,341
7,770 SPEECH '	49,706
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	0
	19,606
8,130 DEPRECI	0
	0
9,510 INTERES	(17,914)
9,520 MISC NO	0
4,220	0
8,100	411,720
9,702	0
5,230	0
	<u>(135,222)</u>

Expenses Fixed Assets

