

Facility Name & ID Number Heritage Health-Gillespie

0048892 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	118	Skilled (SNF)	118	43,070	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	118	TOTALS	118	43,070	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	16,796	8,687	2,912	28,395	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,796	8,687	2,912	28,395	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.93%

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 2,912

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL 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-Gillespie

0048892

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	185,153	9,219		194,372		194,372	5,946	200,318		1
2	Food Purchase		216,998		216,998		216,998	71	217,069		2
3	Housekeeping	106,164	22,528		128,692		128,692		128,692		3
4	Laundry	57,547	15,204		72,751		72,751		72,751		4
5	Heat and Other Utilities			83,401	83,401		83,401	1,622	85,023		5
6	Maintenance	42,240	56,534	51,647	150,421		150,421	20,260	170,681		6
7	Other (specify):*										7
8	TOTAL General Services	391,104	320,483	135,048	846,635		846,635	27,899	874,534		8
	B. Health Care and Programs										
9	Medical Director			16,744	16,744		16,744		16,744		9
10	Nursing and Medical Records	1,542,991	80,873	12,917	1,636,781		1,636,781	345	1,637,126		10
10a	Therapy		371,038	430,402	801,440	(388,024)	413,416		413,416		10a
11	Activities	37,789	3,047		40,836		40,836		40,836		11
12	Social Services	47,095		2,546	49,641		49,641		49,641		12
13	CNA Training							1,000	1,000		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,627,875	454,958	462,609	2,545,442	(388,024)	2,157,418	1,345	2,158,763		16
	C. General Administration										
17	Administrative	95,520			95,520		95,520		95,520		17
18	Directors Fees										18
19	Professional Services			240,870	240,870		240,870	(215,829)	25,041		19
20	Dues, Fees, Subscriptions & Promotions			113,650	113,650	(64,605)	49,045	(28,455)	20,590		20
21	Clerical & General Office Expenses	163,545	27,225	13,774	204,544		204,544	364,707	569,251		21
22	Employee Benefits & Payroll Taxes			550,931	550,931		550,931	60,027	610,958		22
23	Inservice Training & Education			6,037	6,037		6,037	1,782	7,819		23
24	Travel and Seminar			6,453	6,453		6,453	(1,454)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,570	63,570		63,570	13,437	77,007		26
27	Other (specify):*			96,000	96,000		96,000	(96,000)			27
28	TOTAL General Administration	259,065	27,225	1,091,285	1,377,575	(64,605)	1,312,970	98,215	1,411,185		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,278,044	802,666	1,688,942	4,769,652	(452,629)	4,317,023	127,459	4,444,482		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation						222,934	222,934				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,611	24,611		24,611	143,439	168,050			32
33	Real Estate Taxes							30,748	30,748			33
34	Rent-Facility & Grounds			516,840	516,840		516,840	(509,342)	7,498			34
35	Rent-Equipment & Vehicles			12,561	12,561		12,561	9,485	22,046			35
36	Other (specify):*											36
37	TOTAL Ownership			554,012	554,012		554,012	(102,736)	451,276			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					388,024	388,024	23,308	411,332			39
40	Barber and Beauty Shops		1,187	16,186	17,373		17,373		17,373			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					64,605	64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,187	16,186	17,373	452,629	470,002	23,308	493,310			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,278,044	803,853	2,259,140	5,341,037		5,341,037	48,031	5,389,068			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-Gillespie

0048892

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- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27,856)			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	(3,895)			17
18	Fines and Penalties				18
19	Entertainment	(10,903)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,236)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)			24
25	Fund Raising, Advertising and Promotional	(34,175)			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)	\$ (178,065)		\$	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)	226,096		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 226,096		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 48,031		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-Gillespie

ID# 0048892

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line Reference

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		(3,895)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(5,236)	19	22
23				23
24		(96,000)	27	24
25		(34,175)	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		(139,306)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Gillespie# 0048892

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	5,946	0	0	0	0	0	0	0	0	5,946	1
2	Food Purchase	0	0	71	0	0	0	0	0	0	0	0	71	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	1,622	0	0	0	0	0	0	0	0	1,622	5
6	Maintenance	0	0	20,260	0	0	0	0	0	0	0	0	20,260	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,899	0	27,899	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	345	0	0	0	0	0	0	0	0	345	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	1,000	0	0	0	0	0	0	0	0	1,000	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	1,345	0	1,345	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	(5,236)	(234,524)	23,931	0	0	0	0	0	0	0	0	(215,829)	19
20	Fees, Subscriptions & Promotions	(38,070)	0	9,615	0	0	0	0	0	0	0	0	(28,455)	20
21	Clerical & General Office Expenses	0	0	364,707	0	0	0	0	0	0	0	0	364,707	21
22	Employee Benefits & Payroll Taxes	0	0	60,027	0	0	0	0	0	0	0	0	60,027	22
23	Inservice Training & Education	0	0	1,782	0	0	0	0	0	0	0	0	1,782	23
24	Travel and Seminar	(10,903)	0	9,449	0	0	0	0	0	0	0	0	(1,454)	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	13,437	0	0	0	0	0	0	0	0	13,437	26
27	Other (specify):*	(96,000)	0	0	0	0	0	0	0	0	0	0	(96,000)	27
28	TOTAL General Administration	(150,209)	(234,524)	482,948	0	98,215	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(150,209)	(234,524)	512,192	0	127,459	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Gillespie# 0048892

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	199,097	0	23,837	0	0	0	0	0	0	0	222,934	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(27,856)	171,325	0	(30)	0	0	0	0	0	0	0	143,439	32
33	Real Estate Taxes	0	30,748	0	0	0	0	0	0	0	0	0	30,748	33
34	Rent-Facility & Grounds	0	(516,840)	0	7,498	0	0	0	0	0	0	0	(509,342)	34
35	Rent-Equipment & Vehicles	0	0	0	9,485	0	0	0	0	0	0	0	9,485	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,856)	(115,670)	0	40,790	0	(102,736)	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	23,308	0	0	0	0	0	0	0	0	0	23,308	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	23,308	0	0	0	0	0	0	0	0	0	23,308	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(178,065)	(326,886)	512,192	40,790	0	48,031	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 G</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>23,308</u>	<u>23,308</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>234,524</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(234,524)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>516,840</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(516,840)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>30,748</u>	<u>30,748</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>165,646</u>	<u>165,646</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>199,097</u>	<u>199,097</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,679</u>	<u>5,679</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 751,364			\$ 424,478	\$ * (326,886)	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.		\$	\$ 5,946	15
16	V	2 Food Purchase					71	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,622	19
20	V	6 Maintenance					20,260	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					345	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,000	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					23,931	31
32	V	20 Fees, Subscription, Promotions					9,615	32
33	V	21 Clerical & General Office Expenses					364,707	33
34	V	22 Employee Benefits & Payroll Taxes					60,027	34
35	V	23 Inservice Training & Education					1,782	35
36	V	24 Travel and Seminar					9,449	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					13,437	38
39	Total		\$			\$	0	\$ * 512,192 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						23,837	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(30)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						7,498	20	
21	V	35 Rent-Equipment & Vehicles						9,485	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	\$ *	40,790	39

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

Facility Name & ID Number Heritage Health-Gillespie # 0048892 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-Gillespie

0048892

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	118	\$ 5,946	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	118	71	2
3	3	Housekeeping	Beds	2,666	25	0	0	118	0	3
4	4	Laundry	Beds	2,666	25	0	0	118	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	118	1,622	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	118	20,260	6
7	7	Other	Beds	2,666	25	0	0	118	0	7
8	9	Medical Director	Beds	2,666	25	0	0	118	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	118	345	9
10	11	Activities	Beds	2,666	25	0	0	118	0	10
11	12	Social Service	Beds	2,666	25	0	0	118	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	118	1,000	12
13	14	Program Transportation	Beds	2,666	25	0	0	118	0	13
14	15	Other	Beds	2,666	25	0	0	118	0	14
15	17	Administrative	Beds	2,666	25	0	0	118	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	118	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	118	23,931	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	118	9,615	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	118	364,707	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	118	60,027	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	118	1,782	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	118	9,449	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	118	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	118	13,437	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 512,192	25

Facility Name & ID Number Heritage Health-Gillespie

0048892

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	\$	\$	118	\$	1
2	30	Depreciation	Beds	2,666	25	538,548	118	23,837		2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25		118			3
4	32	Interest	Beds	2,666	25	(682)	118	(30)		4
5	33	Real Estate Taxes	Beds	2,666	25		118			5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393	118	7,498		6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306	118	9,485		7
8	36	Other	Beds	2,666	25		118			8
9	38	Medically Nec Transportation	Beds	2,666	25		118			9
10	39	Ancillary Service Centers	Beds	2,666	25		118			10
11	40	Barber and Beauty Shops	Beds	2,666	25		118			11
12	41	Coffee and Gift Shops	Beds	2,666	25		118			12
13	42	Other	Beds	2,666	25		118			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	\$		\$ 40,790	25

Facility Name & ID Number

Heritage Health-Gillespie

0048892

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	Busey Bank		x	Mortgage			\$	\$			\$ 165,646						
2	Busey Bank		x	Loan Fee Amortization							5,679						
3																	
4																	
5																	
Working Capital																	
6	Bank of America		x	Working Capital							24,611						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 195,936						
B. Non-Facility Related*																	
10	Interest Income										(27,856)						
11																	
12	Allocated Corporate										(30)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (27,886)						
15	TOTALS (line 9+line14)						\$	\$			\$ 168,050						

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.)		\$	30,748		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	30,748		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.		\$	30,748		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 style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: right;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: right;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: right;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: right;">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	30,068	10																
	2012	30,785	11																
	2013	30,748	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-Gillespie COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0048892

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>1000040001</u>	_____	\$ 30,640.84	\$ 30,640.84
2.	<u>1000278402</u>	_____	\$ 106.94	\$ 106.94
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>30,747.78</u>	\$ <u>30,747.78</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: 14,677 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>27,045</u>	1
2					2
3	TOTALS			\$ <u>27,045</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	Accumulated Depreciation
4	118			\$ 3,578,055	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9	Roof Repair		1997	2,275				
10	Storage Tank		1997	1,857				
11								
12	Heritage Manor Sign		1996	1,896				
13	Laundry Room A/C		1996	3,019				
14								
15	Garbage Disposal		1998	730				
16	Roof		1998	90,404				
17								
18	Water Heater		1999	3,596				
19	Air Conditioning Unit		1999	1,145				
20	Smoke Dampers/Fire Alarm Replacem		1999	5,802				
21	Interior Painting--Materials and Labor		1999	2,459				
22	Roof		1999	29,985				
23								
24	Interior Painting--Materials and Labor		2000	3,923				
25								
26	Booster Heater		2001	1,903				
27	Telephone System Add-on		2001	62				
28								
29	A/C Rooftop Unit		2002	2,703				
30								
31								
32								
33	C/O Allocation				23,837		23,837	
34	Book Depreciation				160,886		160,886	
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-Gillespie

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	A/C Units	2003	\$ 8,858	\$		\$	\$	\$	37
38	Asphalt Sealing	2003	2,408						38
39	Ansul System --Kitchen	2003	1,465						39
40									40
41	Front Door	2004	3,893						41
42	Heat Cool Unit	2004	4,522						42
43									43
44	Windows	2005	6,255						44
45	HVAC	2005	10,675						45
46	Rooftop A/C	2005	6,663						46
47	Parking Lot Sealer	2005	2,358						47
48	Wallcoverings	2005	597						48
49	Sidewalks	2005	4,444						49
50	Floor Replacement	2005	18,756						50
51	Boiler	2005	6,388						51
52									52
53	A/C Units	2006	6,865						53
54	Rooftop A/C	2006	8,234						54
55	Five Ton Condensing Unit	2006	2,980						55
56	Pump	2006							56
57	Exterior Door	2006							57
58	Boiler	2006	5,396						58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,830,571	\$ 184,723		\$ 184,723	\$	\$	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		\$ 3,830,571	\$ 184,723		\$ 184,723	\$	\$	1
2	HVAC	2007	3,430						2
3	Steamer Install	2007							3
4	Corridor Remodel	2007							4
5	HVAC	2007	3,024						5
6	Sprinkler Heads	2007	2,569						6
7	Boiler	2007	11,881						7
8	Plumbing	2007	2,949						8
9									9
10	Facility Rehab -- Paint, flooring, lighting	2008	227,268						10
11	Exterior Door	2008	4,150						11
12	Boilers	2008	16,293						12
13	Nurse Call System	2008	123,168						13
14	Window Replacement	2008	54,925						14
15	Parking Lot	2008	37,142						15
16	Wireless System	2008	10,017						16
17	Cabling	2008	5,785						17
18	Alarm System	2008	8,804						18
19									19
20	Rehab: Paint, window treatments, paint & labor	2009	27,218						20
21	Landscaping rock	2009	4,501						21
22	Rooftop A/C	2009	8,678						22
23	Sewer pump	2009	9,150						23
24	Nurse Call System	2009	88,196						24
25									25
26	Carpeting: conference room		2,929						26
27	Relocate/Install data equipment		10,251						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,492,899	\$ 184,723		\$ 184,723	\$	\$	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		\$ 4,492,899	\$ 184,723		\$ 184,723	\$	\$	1
2	PTAC units	2011	7,591						2
3	Condensing Unit	2011	5,461						3
4	Condensing Unit	2011	11,480						4
5	Carpet	2011	24,911						5
6	PTAC units	2011	3,796						6
7	Resident Room Flooring	2011	13,125						7
8									8
9	Carpet	2012	3,332						9
10	Shower Room	2012	8,493						10
11	Water Heater	2012	3,632						11
12	Walk-in Cooler	2012	33,299						12
13	Lighting Upgrade	2012	5,446						13
14									14
15	Front Parking Lot Paving	2013	53,996						15
16	Water Heater	2013	6,750						16
17	PTAC Units	2013	4,089						17
18									18
19	Replace 6 PTAC Units	2014	6,686						19
20	Remove and Rebuild Exterior Wall	2014	8,583						20
21	Parking Lot Fill, Seal and Striping	2014	4,386						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)		\$ 4,697,955	\$ 184,723		\$ 184,723	\$	\$	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	\$ 864,321	\$ 38,211	\$ 38,211	\$		\$	71
72	Current Year Purchases	12,933						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 877,254	\$ 38,211	\$ 38,211	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,602,254	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,934	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,934	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: None

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: \$ 12,561 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 192,747	\$		\$ 192,747	1
2	Licensed Speech and Language Development Therapist		hrs			67,723			67,723	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			147,815	5,131		152,946	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				365,907		365,907	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					22,117			22,117	13
14	TOTAL			\$		\$ 430,402	\$ 371,038		\$ 801,440	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-Gillespie# 0048892Report 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	\$ 350	\$	1
2	Cash-Patient Deposits	4,629		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	886,487		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,015		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(141,546)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 772,935	\$	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)	\$ 772,935	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 202,392	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,629		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	266,327		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,604		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>	63,001		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 539,953	\$	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)	\$ 539,953	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 232,982	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 772,935	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 91,374	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 91,374	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	141,608	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)	\$ 141,608	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)	\$ 232,982	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,946,020	1
2	Discounts and Allowances for all Levels	(1,642,434)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,303,586	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,416,980	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,416,980	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	235	12
13	Barber and Beauty Care	17,797	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	712,965	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,226	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 734,223	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	27,856	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,856	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)	\$ 5,482,645	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	846,635	31
32	Health Care	2,545,442	32
33	General Administration	1,377,575	33
B. Capital Expense			
34	Ownership	554,012	34
C. Ancillary Expense			
35	Special Cost Centers	17,373	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,341,037	40
41	Income before Income Taxes (line 30 minus line 40)**	141,608	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 141,608	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-Gillespie

0048892

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	1,964	2,089	\$ 66,101	\$ 31.64	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	6,762	7,271	180,606	24.84	3
4	Licensed Practical Nurses	16,938	18,213	405,222	22.25	4
5	CNAs & Orderlies	60,023	64,541	804,472	12.46	5
6	CNA Trainees		0			6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,896	4,189	86,590	20.67	8
9	Activity Director					9
10	Activity Assistants	3,438	3,697	37,789	10.22	10
11	Social Service Workers	1,855	1,995	47,095	23.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,837	18,104	185,153	10.23	15
16	Dishwashers					16
17	Maintenance Workers	2,657	2,857	42,240	14.78	17
18	Housekeepers	10,288	11,062	106,164	9.60	18
19	Laundry	5,332	5,733	57,547	10.04	19
20	Administrator	1,900	2,080	95,520	45.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,239	7,784	163,545	21.01	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)	139,129	149,615	\$ 2,278,044 *	\$ 15.23	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	16,744		36
37	Medical Records Consultant	1,137		37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,080		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	2,546		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 27,507		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jean Strausbaugh			\$ 95,520	Workers' Compensation Insurance	\$ 56,496	IDPH License Fee	\$	
				Unemployment Compensation Insurance	39,450	Advertising: Employee Recruitment	1,776	
				FICA Taxes	174,270	Health Care Worker Background Check (Indicate # of checks performed _____)	1,191	
				Employee Health Insurance	269,506	Patient Background Checks		
				Employee Meals			25,910	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Benefits	11,209	Dues & Subscriptions	6,970	
				Central Office Allocation	60,027	License & Fees	4,933	
						Central Office Allocation	9,615	
						Less: Public Relations Expense	(25,910)	
						Non-allowable advertising	(3,895)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,520	TOTAL (agree to Schedule V, line 22, col.8)	\$ 610,958	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,590	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								5,485
								18
							Seminar Expense	950
								(1,454)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
C. Professional Services								
Vendor/Payee	Type	Amount						
Heritage Operations Group		\$	235,634					
Legal adj to Zero			5,236					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 240,870					

* Attach copy of IMRF notifications

**See instructions.

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

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

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. \$ 64,605
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. \$ 510
- (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	350						1,009	1,009 PETTY CASH 350
1010	CASH IN BANK							1,100	1,100 ACCTS R 886,487
1040	CASH IN BANK-PAYROLL							1,101	1,101 ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	886,487						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 23,015
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	23,015						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 4,629
1490	ACCUM DEPR-BUILDING	0						1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	4,629						1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850 INTERCO (141,546)
1560	REAL ESTATE TAX ESCROW							2,010	2,010 ACCOUN (202,392)
1575	REIMBURSABLE PURCHASES							2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-141,546						2,100	2,100 ACCRUEI (112,602)
2010	ACCOUNTS PAYABLE	-202,392						2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-112,602						2,110	2,110 ACCRUEI (153,725)
2110	ACCRUED VACATION PAY	-153,725						2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(3,604)	
2125	FICA TAX PAYABLE	-3,604	-3,604	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	(63,001)	
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-63,001		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(4,629)	
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	(91,374)	
2460	INCOME TAXES PAYABLE					net income	(141,608)
2512	DUE TO RESIDENTS	-4,629					
2600	MORTGAGE PAYABLE	0				balance	<u>0</u>
2650	EQUIPMENT LOAN PAYABLE						
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-91,374					
2970	PROFIT/LOSS FOR PERIOD	-141,608					
3007.1	PATIENT DAYS-PRIVATE	8,687					3,007

3007.2	PATIENT DAYS-IPA	16,796						3,007
3007.3	PATIENT DAYS-MEDICARE	2,912						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE & VA	-4,913,521	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	-32,499	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	-712,965	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,416,980	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	1,642,434	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	-17,797		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-125		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-110		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	0		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-3,226		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	155,274	163,545	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	95,520	95,520	17	1	0	0		4,120
4115	VACATION & SICK - G&A	8,271		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	12,184	550,931	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	-975		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255 OFFICE SUPPLIES	27,225	27,225	21	2	0	0		4,275
4260	TELEPHONE	13,774	13,774	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	6,037	6,037	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	5,485	6,453	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	18		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	950		24	3	19	-10,903 ***		4,289
4290	HELP WANTED ADVERTISING	1,776	113,650	20	3	0	0 -64,605		4,290
4291	PROMOTIONAL ADVERTISING	8,265		20	3	25	-8,265		4,291
4292	PUBLIC RELATIONS	25,910		20	3	25	-25,910		4,292
4300	LICENSES & FEES	69,538		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	6,970		20	3	17	-3,895		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	6,346	240,870	19	3	22	-5,236		4,350
4355	MEDICAL DIRECTOR	16,744	16,744	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	1,137		10	3	0	0	4,364
4363	PHARMACIST FEES	7,080		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	2,546	2,546	12	3	0	0	4,383
4370	TV RENTAL	8,648		35	3	5	0	4,390
4380	INCOME TAXES		96,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,191		20	3	26	0	4,401
4400	PAYROLL TAXES	203,805		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	9,915		22	3	0	0	4,420
4410	GROUP INSURANCE	269,506		22	3	0	0	4,430
4420	LIABILITY INSURANCE	63,570	63,570	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	56,496		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	234,524		19	3	34	0 **	4,460
4460	BAD DEBTS	96,000		27	3	24	-96,000	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	3,913	12,561	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	36,584	42,240	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	5,656		6	1	0	0	4,510
5130	ELECTRIC	44,367	83,401	5	3	0	0	4,600
5131	NATURAL GAS	24,992		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	14,042		5	3	0	0	5,130
5134	TRASH COLLECTION	13,175	51,647	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	21,958	56,534	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	34,576		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	38,472		6	3	0	0	5,140
5210	DIETARY WAGES	173,091	185,153	1	1	0	0	5,160
5220	DIETARY SICK & VAC	12,062		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	217,508	216,998	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,514	9,219	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,322		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	5,383		1	2	0	0	5,260
5295	MEAL CREDIT	-510		2	2	0	0	5,270
5310	LAUNDRY WAGES	55,022	57,547	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,525		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	9,984	15,204	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,220		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	100,682	106,164	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	5,482		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	20,000	22,528	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	2,528		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,542,991	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	165,657		10	1	0	0	6,020
6030	DON WAGES	66,101		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	14,949		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	369,714		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	35,508		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	739,657		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	64,815		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	80,242		10	1	0	0	6,390
6275	REHAB SICK & VAC	6,348		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	66,154	80,873	10	2	0	0	7,281
6295	NURSING SUPPLIES	12,695		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	2,024		10	2	0	0	7,391
6490	NURSING OTHER	4,700	12,917	10	3	0	0	7,393
7280	DRUG PURCHASES	114,312	371,038	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	251,595		39	2			7,540
7380	LABORATORY SERVICES	22,117	430,402	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	35,735	37,789	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	2,054		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	3,047	3,047	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	147,815		39	3	0	0 ***	7,890
7660	PT SUPPLIES	5,131		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	44,533	47,095	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	2,562		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	192,747		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	67,723		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	16,186	16,186	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	1,187	1,187	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	516,840	516,840	34	3	0	0	

8120	INTEREST EXPENSE	24,611	24,611	32	3	14	-27,856	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-27,856		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

5,313,181 5,341,037
27,856

GRAND TOTALS

-141,608 -178,065
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	8,687	8,687
IPA	16,796	16,796
medic	2,912	2,912
		28,395

S

JND

IA

T

T

3,007 PATIENT	16,796
3,007 PATIENT	2,912
	0
3,010 BASIC CI	(4,913,521)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(32,499)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(712,965)
	0
3,110 PHYSICIAN	(1,416,980)
	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	1,579,021

3,520 RENT INC	0
3,530 BEAUTY	(17,797)
	(125)
3,570 VENDING	(110)
3,590 EQUIPMI	0
3,595 RESIDEN	(3,226)
3,600 MISC INC	0
4,110 G&A WA	155,274
4,111 ADMINIS	95,520
4,115 G&A PTC	8,271
4,120 EMPLOY	13,035
4,130 EMPLOY	0
4,135 EMPLOY	(975)
4,250 OFFICE S	9,518
4,255 POSTAGI	4,189
4,260 TELEPHC	13,774
4,275 TRAININ	6,037
	(12)
4,280 GENERA	5,485
4,281 MEAL EX	18
4,285 EDUCAT	950
4,289 MEETING	0
4,290 HELP WA	1,776
4,291 PROMOT	8,265
4,292 PUBLIC I	25,910
4,300 LICENSE	69,538
4,310 DUES & :	6,970
4,320 CONTRIE	0
4,350 PROFESS	6,346
4,355 MEDICAL	16,744
	1,137
	7,080

4,364 SOCIAL S	2,546
4,370 TV RENT	8,648
4,383 BACKGR	1,191
4,390 OTHER T	0
4,400 PAYROL	203,805
4,401 PAYROL	9,915
4,410 GROUP I	269,506
4,420 LIABILIT	63,570
4,430 WORKM	55,868
4,435 W/C-FIRS	0
4,436 DRUG TE	640
4,450 MANAGI	234,524
4,460 BAD DEF	96,000
4,461 BAD DEF	63,413
4,470 LOST ITE	0
4,475 UNIFORM	(851)
4,486 SERVICE	21,769
4,490 MISC EX	49
4,496 MISC. M.	13,518
4,510 REAL ES	0
4,600 LEASED	3,913
5,110 MAINTEI	36,584
5,120 MAINTEI	5,656
5,130 ELECTRI	44,367
5,131 NATURA	24,992
5,133 WATER &	14,042
5,134 TRASH C	13,175
5,140 PROP/PL	21,958
5,160 GENERA	34,576
5,165 MAINTEI	16,703
5,210 DIETARY	173,091
5,220 DIETARY	12,062
5,248 FOOD PU	217,459

5,250 SUPPLIE	2,514
5,260 REPLACI	1,322
5,270 KITCHEN	5,383
5,295 MEAL IN	(510)
5,310 LAUNDR	55,022
5,340 LAUNDR	2,525
5,370 REPLACI	9,984
	0
5,390 SUPPLIE	5,220
5,410 HOUSEK	100,682
5,440 HOUSEK	5,482
5,480 SUPPLIE	20,000
5,490 SUPPLIE	2,528
6,020 RN WAG	165,657
6,030 DON WA	66,101
6,035 ADON W	0
6,040 RN PTO	14,949
6,120 LPN WAG	369,714
6,140 LPN PTO	35,508
6,220 AIDES W	739,657
6,240 AIDES PT	64,815
6,245	0
	0
	0
	0
6,270 REHAB V	80,242
6,275 REHAB F	6,348
6,290 NURSINC	66,154
6,295 NURSINC	12,695
6,390 REPLACI	2,024
6,490 OTHER	4,700

7,280 DRUG PU	114,312
7,281 DRUG PU	251,595
7,380 LABORA	5,386
7,390 X-RAY S	16,731
	0
7,510 ACTIVIT	35,735
7,540 ACTIVIT	2,054
7,590 ACTIVIT	3,047
7,620 PHYSICA	147,815
7,660 P.T. SUPE	5,131
7,710 SOCIAL S	44,533
7,720 SOCIAL S	2,562
7,730 SOCIAL S	0
7,740 OCCUPA	192,747
7,770 SPEECH '	67,723
7,820 BEAUTIC	16,186
	1,187
	0
8,120 INTERES	0
	24,611
8,130 DEPRECI	0
	0
9,510 INTERES	(27,856)
9,520 MISC NO	0
4,220	0
8,100	516,840
9,702	0
5,230	0
	<u>(141,608)</u>

Expenses Fixed Assets

