

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0048900</u></p> <p>Facility Name: <u>Heritage Health-Litchfield</u></p> <p>Address: <u>628 S Illinois St</u> <u>Litchfield</u> <u>62056</u> <small>Number City Zip Code</small></p> <p>County: <u>Montgomery</u></p> <p>Telephone Number: <u>(217) 324-2153</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2007</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dave Underwood</u> Telephone Number: <u>309 823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP & CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # () </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP & CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP & CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Heritage Health-Litchfield

0048900 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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	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	14,436	6,890	4,318	25,644	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,436	6,890	4,318	25,644	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.88%

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 4,318

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.

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	175,557	11,457		187,014		187,014	5,140	192,154		1
2	Food Purchase		194,708		194,708		194,708	61	194,769		2
3	Housekeeping	103,548	32,979		136,527		136,527		136,527		3
4	Laundry	43,508	19,894		63,402		63,402		63,402		4
5	Heat and Other Utilities			84,096	84,096		84,096	1,402	85,498		5
6	Maintenance	65,863	49,010	59,060	173,933		173,933	17,513	191,446		6
7	Other (specify):*										7
8	TOTAL General Services	388,476	308,048	143,156	839,680		839,680	24,116	863,796		8
	B. Health Care and Programs										
9	Medical Director			28,516	28,516		28,516		28,516		9
10	Nursing and Medical Records	1,459,686	82,691	7,595	1,549,972		1,549,972	298	1,550,270		10
10a	Therapy		365,969	654,555	1,020,524	(391,619)	628,905		628,905		10a
11	Activities	40,078	2,176		42,254		42,254		42,254		11
12	Social Services	58,271		1,590	59,861		59,861		59,861		12
13	CNA Training							864	864		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,558,035	450,836	692,256	2,701,127	(391,619)	2,309,508	1,162	2,310,670		16
	C. General Administration										
17	Administrative	96,793			96,793		96,793		96,793		17
18	Directors Fees										18
19	Professional Services			245,797	245,797		245,797	(225,498)	20,299		19
20	Dues, Fees, Subscriptions & Promotions			76,298	76,298	(55,845)	20,453	(5,621)	14,832		20
21	Clerical & General Office Expenses	90,129	21,399	10,014	121,542		121,542	315,255	436,797		21
22	Employee Benefits & Payroll Taxes			494,173	494,173		494,173	51,888	546,061		22
23	Inservice Training & Education			5,590	5,590		5,590	1,540	7,130		23
24	Travel and Seminar			4,478	4,478		4,478	521	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			45,144	45,144		45,144	11,615	56,759		26
27	Other (specify):*			18,050	18,050		18,050	(18,000)	50		27
28	TOTAL General Administration	186,922	21,399	899,544	1,107,865	(55,845)	1,052,020	131,700	1,183,720		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,133,433	780,283	1,734,956	4,648,672	(447,464)	4,201,208	156,978	4,358,186		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-Litchfield

#0048900

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							233,860	233,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,276	21,276		21,276	96,115	117,391			32
33	Real Estate Taxes							72,011	72,011			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,279)	6,481			34
35	Rent-Equipment & Vehicles			10,372	10,372		10,372	8,199	18,571			35
36	Other (specify):*											36
37	TOTAL Ownership			478,408	478,408		478,408	(30,094)	448,314			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					391,619	391,619	(12,134)	379,485			39
40	Barber and Beauty Shops		666	10,961	11,627		11,627		11,627			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,845	55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		666	10,961	11,627	447,464	459,091	(12,134)	446,957			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,133,433	780,949	2,224,325	5,138,707		5,138,707	114,750	5,253,457			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-Litchfield

0048900

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	(9,837)			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	(3,051)			17
18	Fines and Penalties				18
19	Entertainment	(7,647)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,894)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(10,882)			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)	\$ (56,311)		\$	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)	171,061		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 171,061		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 114,750		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-Litchfield

ID# 0048900

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		(3,051)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(6,894)	19	22
23				23
24		(18,000)	27	24
25		(10,882)	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		(38,827)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Litchfield# 0048900

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,140	0	0	0	0	0	0	0	0	5,140	1
2	Food Purchase	0	0	61	0	0	0	0	0	0	0	0	61	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	1,402	0	0	0	0	0	0	0	0	1,402	5
6	Maintenance	0	0	17,513	0	0	0	0	0	0	0	0	17,513	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	24,116	0	0	0	0	0	0	0	0	24,116	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	298	0	0	0	0	0	0	0	0	298	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	864	0	0	0	0	0	0	0	0	864	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	1,162	0	0	0	0	0	0	0	0	1,162	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	(6,894)	(239,290)	20,686	0	0	0	0	0	0	0	0	(225,498)	19
20	Fees, Subscriptions & Promotions	(13,933)	0	8,312	0	0	0	0	0	0	0	0	(5,621)	20
21	Clerical & General Office Expenses	0	0	315,255	0	0	0	0	0	0	0	0	315,255	21
22	Employee Benefits & Payroll Taxes	0	0	51,888	0	0	0	0	0	0	0	0	51,888	22
23	Inservice Training & Education	0	0	1,540	0	0	0	0	0	0	0	0	1,540	23
24	Travel and Seminar	(7,647)	0	8,168	0	0	0	0	0	0	0	0	521	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	11,615	0	0	0	0	0	0	0	0	11,615	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	TOTAL General Administration	(46,474)	(239,290)	417,464	0	0	0	0	0	0	0	0	131,700	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,474)	(239,290)	442,742	0	0	0	0	0	0	0	0	156,978	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Litchfield

0048900

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	213,255	0	20,605	0	0	0	0	0	0	0	233,860	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,837)	105,978	0	(26)	0	0	0	0	0	0	0	96,115	32
33	Real Estate Taxes	0	72,011	0	0	0	0	0	0	0	0	0	72,011	33
34	Rent-Facility & Grounds	0	(446,760)	0	6,481	0	0	0	0	0	0	0	(440,279)	34
35	Rent-Equipment & Vehicles	0	0	0	8,199	0	0	0	0	0	0	0	8,199	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,837)	(55,516)	0	35,259	0	(30,094)	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	(12,134)	0	0	0	0	0	0	0	0	0	(12,134)	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	(12,134)	0	0	0	0	0	0	0	0	0	(12,134)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(56,311)	(306,940)	442,742	35,259	0	114,750	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>(12,134)</u>	<u>(12,134)</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>239,290</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(239,290)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>446,760</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(446,760)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>72,011</u>	<u>72,011</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>100,075</u>	<u>100,075</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>213,255</u>	<u>213,255</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,903</u>	<u>5,903</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 686,050			\$ 379,110	\$ * (306,940)	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.		\$	\$ 5,140	15
16	V	2 Food Purchase					61	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,402	19
20	V	6 Maintenance					17,513	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					298	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					864	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					20,686	31
32	V	20 Fees, Subscription, Promotions					8,312	32
33	V	21 Clerical & General Office Expenses					315,255	33
34	V	22 Employee Benefits & Payroll Taxes					51,888	34
35	V	23 Inservice Training & Education					1,540	35
36	V	24 Travel and Seminar					8,168	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					11,615	38
39	Total		\$			\$	0	\$ * 442,742 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						20,605	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(26)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						6,481	20	
21	V	35 Rent-Equipment & Vehicles						8,199	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	\$ *	35,259	39

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

Facility Name & ID Number Heritage Health-Litchfield # 0048900 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-Litchfield

0048900

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	102	\$ 5,140	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	102	61	2
3	3	Housekeeping	Beds	2,666	25	0	0	102	0	3
4	4	Laundry	Beds	2,666	25	0	0	102	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	102	1,402	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	102	17,513	6
7	7	Other	Beds	2,666	25	0	0	102	0	7
8	9	Medical Director	Beds	2,666	25	0	0	102	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	102	298	9
10	11	Activities	Beds	2,666	25	0	0	102	0	10
11	12	Social Service	Beds	2,666	25	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	102	864	12
13	14	Program Transportation	Beds	2,666	25	0	0	102	0	13
14	15	Other	Beds	2,666	25	0	0	102	0	14
15	17	Administrative	Beds	2,666	25	0	0	102	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	102	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	102	20,686	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	102	8,312	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	102	315,255	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	102	51,888	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	102	1,540	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	102	8,168	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	102	11,615	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 442,742	25

Facility Name & ID Number Heritage Health-Litchfield

0048900

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	\$	\$	102	\$	1
2	30	Depreciation	Beds	2,666	25	538,548		102	20,605	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25			102		3
4	32	Interest	Beds	2,666	25	(682)		102	(26)	4
5	33	Real Estate Taxes	Beds	2,666	25			102		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393		102	6,481	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306		102	8,199	7
8	36	Other	Beds	2,666	25			102		8
9	38	Medically Nec Transportation	Beds	2,666	25			102		9
10	39	Ancillary Service Centers	Beds	2,666	25			102		10
11	40	Barber and Beauty Shops	Beds	2,666	25			102		11
12	41	Coffee and Gift Shops	Beds	2,666	25			102		12
13	42	Other	Beds	2,666	25			102		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	\$		\$ 35,259	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	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			\$	\$		\$ 100,075	1									
2	Busey Bank		x	Loan Fee Amortization						5,903	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						21,276	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 127,254	9									
B. Non-Facility Related*																				
10	Interest Income									(9,837)	10									
11											11									
12	Allocated Corporate									(26)	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (9,863)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 117,391	15									

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	72,011		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	72,011		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.		\$	72,011		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	_____	8	FOR BHF USE ONLY		
	2010	_____	9			
	2011	73,980	10			
	2012	71,673	11			
	2013	72,011	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0048900

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>1504279009</u>	_____	\$ 68,846.64	\$ 68,846.64
2.	<u>1504278012</u>	_____	\$ 226.24	\$ 226.24
3.	<u>1504279015</u>	_____	\$ 2,938.22	\$ 2,938.22
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>72,011.10</u>	\$ <u>72,011.10</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-Litchfield

0048900 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 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>6,816</u>	1
2					2
3	TOTALS			\$ <u>6,816</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	102			\$ 3,364,350	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Symmons Mixing Valve		1997	2,000					9
10	Boiler		1997	5,612					10
11	Dinning Room Roof Repair		1997	2,755					11
12	Roof Repair		1997	3,280					12
13									13
14	Laundry Room Central Air		1996	3,019					14
15	Heritage Manor Sign		1996	2,173					15
16									16
17	Roof		1998	60,674					17
18	Booster Heater		1998	1,717					18
19	Heat/Cool Units		1998	3,433					19
20	Garbage Disposal		1998	730					20
21									21
22									22
23									23
24									24
25									25
26			1999	920					26
27	Recirculating Pump		1999	2,046					27
28	Plumbing repairs/Replacement		1999	10,045					28
29	Carpet		1999	2,335					29
30									30
31									31
32									32
33	C/O Allocation				20,605		20,605		33
34	Book Depreciation				163,700		163,700		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	Rooftop A/C Unit	2000	\$ 3,348	\$		\$	\$	\$	37
38	Blacktop Walkway	2000	2,250						38
39	Gazebo	2000	7,675						39
40									40
41	A/C Unit	2001	3,879						41
42	Gazebo	2001	981						42
43									43
44	A/C Unit	2002	1,453						44
45	A/C Unit	2002	3,120						45
46	Disposal	2002	794						46
47	Boiler	2002	1,453						47
48									48
49	A/C Unit	2003	3,458						49
50	A/C Unit	2003	833						50
51	A/C Unit	2003	2,440						51
52	A/C Unit	2003	4,542						52
53	Food Processor	2003	1,227						53
54	Ansul System	2003	1,271						54
55									55
56	Heat/Cool Units	2004	7,437						56
57	Resurface Parking Lot	2004	30,570						57
58	Roof Repair	2004	6,110						58
59	Rooftop A/C Unit	2004	3,479						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)		\$ 3,551,409	\$ 184,305		\$ 184,305	\$	\$	70

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

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		\$ 3,551,409	\$ 184,305		\$ 184,305	\$	\$	1
2	Disposal	2005	842						2
3	Electrical Service	2005	8,421						3
4	A/C Units	2005	5,786						4
5	Boiler	2005	3,863						5
6	Exterior Lights	2005	1,095						6
7	Interior Remodel-- paint, wallcoverings	2005	49,155						7
8	Roof	2005	70,055						8
9	Exterior Door	2005	1,158						9
10	adjustments	2005	(4,948)						10
11	Storage Tank Replacement	2006	2,474						11
12	A/C Units	2006	13,308						12
13	Sidewalk	2006	4,566						13
14	A/C Units	2006	1,250						14
15	Exterior Door	2006	30						15
16	Roof	2006	98,093						16
17	adjustments	2006	(13,947)						17
18	HVAC	2007	6,631						18
19	Boiler	2007	1,363						19
20	Fire Panel	2007	2,007						20
21	Corridor Rehab --Paint	2007	32,114						21
22	Rheem Storage Tank	2007	3,422						22
23	Front Entry Doors	2007	4,450						23
24	Fire System	2007	6,769						24
25	Nurse Call	2007	2,565						25
26	Asbestos	2007	253						26
27	adjustments	2007	(6,680)						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,845,504	\$ 184,305		\$ 184,305	\$	\$	34

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,845,504	\$ 184,305		\$ 184,305	\$	\$	1
2	Corridor Rehab-- Paint	2008	11,629						2
3	Electrical Panel	2008							3
4	A/C -- Kitchen & Conf Room	2008	6,660						4
5	HVAC Boiler	2008	11,252						5
6	Exterior Rehab	2008	3,155						6
7	Nurse Call	2008	2,688						7
8	Landscaping	2008							8
9	Siding Laundry	2008	25,650						9
10	Sprinkler	2008	25,062						10
11									11
12	Resident Rm Remodel:paint, flooring & labor	2009	230,727						12
13	Backflow Preventor	2009	5,980						13
14	Windows	2009	38,840						14
15	Sprinkler system	2009	9,386						15
16	Nurse Call	2009	239,661						16
17									17
18	Resident Rm Remodel:paint, flooring & labor	2010	14,010						18
19	Generator	2010	17,868						19
20	Water Softener	2010	4,500						20
21									21
22	Air Conditioner	2011	4,680						22
23	Asphalt	2011	3,276						23
24	Water Heater	2011	13,603						24
25	Sign	2011	4,025						25
26	Exterior Windows	2011	40,675						26
27									27
28	Lighting Upgrade	2012	4,555						28
29	Computer Data Interface	2012	4,818						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,568,204	\$ 184,305		\$ 184,305	\$	\$	34

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

Facility Name & ID Number Heritage Health-Litchfield

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,568,204	\$ 184,305		\$ 184,305	\$	\$	1
2									2
3	Drain Line Replacement	2013	5,725						3
4	PTAC's	2013	7,655						4
5									5
6	Replace 7 PTAC Units	2014	5,530						6
7	Replace Drainage System	2014	4,544						7
8	(2) Boiler Replacements	2014	27,219						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,618,877	\$ 184,305		\$ 184,305	\$	\$	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	\$ 803,171	\$ 49,555	\$ 49,555	\$		\$	71
72	Current Year Purchases	12,523						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 815,694	\$ 49,555	\$ 49,555	\$		\$	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)	\$ 5,441,387	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,860	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 233,860	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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: \$ 10,372 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Health-Litchfield # 0048900 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 309,596	\$		\$ 309,596	1
2	Licensed Speech and Language Development Therapist		hrs				69,705			69,705	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				246,684	2,920		249,604	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					363,049		363,049	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						28,570			28,570	13
14	TOTAL			\$			\$ 654,555	\$ 365,969		\$ 1,020,524	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-Litchfield# 0048900Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 493	\$	1
2	Cash-Patient Deposits	4,701		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	920,608		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,915		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(242,586)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 726,131	\$	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)	\$ 726,131	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 228,480	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,701		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	220,920		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,312		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>	55,073		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 510,486	\$	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)	\$ 510,486	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 215,645	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 726,131	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (193,110)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (193,110)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	408,755	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)	\$ 408,755	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)	\$ 215,645	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	\$ 4,937,557	1	
2	Discounts and Allowances for all Levels	(2,289,222)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,648,335	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,160,895	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,160,895	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	310	12	
13	Barber and Beauty Care	13,109	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	714,976	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)	\$ 728,395	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	9,837	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,837	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)	\$ 5,547,462	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	839,680	31	
32	Health Care	2,701,127	32	
33	General Administration	1,107,865	33	
B. Capital Expense				
34	Ownership	478,408	34	
C. Ancillary Expense				
35	Special Cost Centers	11,627	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)*	\$ 5,138,707	40	
41	Income before Income Taxes (line 30 minus line 40)**	408,755	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 408,755	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-Litchfield

0048900

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	1,976	2,196	\$ 64,262	\$ 29.26	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	7,508	8,073	213,046	26.39	3
4	Licensed Practical Nurses	17,657	18,986	422,886	22.27	4
5	CNAs & Orderlies	56,071	60,291	759,492	12.60	5
6	CNA Trainees		0			6
7	Licensed Therapist					7
8	Rehab/Therapy Aides		0			8
9	Activity Director					9
10	Activity Assistants	2,983	3,208	40,078	12.49	10
11	Social Service Workers	3,169	3,408	58,271	17.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,070	15,129	175,557	11.60	15
16	Dishwashers					16
17	Maintenance Workers	4,404	4,735	65,863	13.91	17
18	Housekeepers	9,137	9,825	103,548	10.54	18
19	Laundry	4,405	4,737	43,508	9.18	19
20	Administrator	1,900	2,080	96,793	46.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,057	4,362	90,129	20.66	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)	127,337	137,030	\$ 2,133,433 *	\$ 15.57	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	28,516		36
37	Medical Records Consultant	1,026		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,120		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	1,590		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 37,252		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	
Marge Oblinger			\$ 96,793	Workers' Compensation Insurance	\$ 44,320	IDPH License Fee	\$	
				Unemployment Compensation Insurance	36,467	Advertising: Employee Recruitment	1,513	
				FICA Taxes	163,208	Health Care Worker Background Check (Indicate # of checks performed _____)	1,162	
				Employee Health Insurance	241,125	Patient Background Checks		
				Employee Meals			6,094	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,727	
						License & Fees	1,169	
				Other Benefits	9,053	Central Office Allocation	8,312	
				Central Office Allocation	51,888	Less: Public Relations Expense	(6,094)	
						Non-allowable advertising	(3,051)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 96,793				\$ 546,061			\$ 14,832	
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	
								3,607
								252
							Seminar Expense	619
								521
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL	
\$				\$			\$ 4,999	
C. Professional Services								
Vendor/Payee	Type	Amount						
Heritage Operations Group		\$ 238,903						
Legal adj to Zero		6,894						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 245,797								

* 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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Litchfield

0048900

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. \$ 55,845
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. \$ 1,450
- (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	493						1,009	1,009	PETTY CASH 493
1010	CASH IN BANK							1,100	1,100	ACCTS R 920,608
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	920,608						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 42,915
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	42,915						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 4,701
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FE 0
1530	RESIDENT FUNDS	4,701						1,551	1,551	LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850	INTERCO (242,586)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN (228,480)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
1850	INTRACOMPANY	-242,586						2,100	2,100	ACCRUEI (107,170)
2010	ACCOUNTS PAYABLE	-228,480						2,100	2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-107,170						2,110	2,110	ACCRUEI (113,750)
2110	ACCRUED VACATION PAY	-113,750						2,120	2,120	U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(1,312)	
2125	FICA TAX PAYABLE	-1,312	-1,312	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	(55,073)	
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-55,073		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(4,701)	
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	193,110	
2460	INCOME TAXES PAYABLE					net income	(408,755)
2512	DUE TO RESIDENTS	-4,701					
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	193,110					
2970	PROFIT/LOSS FOR PERIOD	-408,755					
3007.1	PATIENT DAYS-PRIVATE	6,890					3,007

3007.2	PATIENT DAYS-IPA	14,436						3,007
3007.3	PATIENT DAYS-MEDICARE	4,318						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	-4,910,150	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	-18,950	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	-714,976	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,160,895	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	2,289,222	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	-13,109		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-310		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-8,457		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	80,683	90,129	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	96,793	96,793	17	1	0	0		4,120
4115	VACATION & SICK - G&A	9,446		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	9,053	494,173	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	21,399	21,399	21	2	0	0		4,275
4260	TELEPHONE	10,014	10,014	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	5,590	5,590	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	3,607	4,478	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	252		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	619		24	3	19	-7,647 ***		4,289
4290	HELP WANTED ADVERTISING	1,513	76,298	20	3	0	0 -55,845		4,290
4291	PROMOTIONAL ADVERTISING	4,788		20	3	25	-4,788		4,291
4292	PUBLIC RELATIONS	6,094		20	3	25	-6,094		4,292
4300	LICENSES & FEES	57,014		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	5,727		20	3	17	-3,051		4,310
4320	CONTRIBUTIONS	50		27	3	20	0		4,320
4350	PROFESSIONAL FEES	6,507	245,797	19	3	22	-6,894		4,350
4355	MEDICAL DIRECTOR	28,516	28,516	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	1,026		10	3	0	0	4,364
4363	PHARMACIST FEES	6,120		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	1,590	1,590	12	3	0	0	4,383
4370	TV RENTAL	6,459		35	3	5	0	4,390
4380	INCOME TAXES		18,050	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,162		20	3	26	0	4,401
4400	PAYROLL TAXES	189,628		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	10,047		22	3	0	0	4,420
4410	GROUP INSURANCE	241,125		22	3	0	0	4,430
4420	LIABILITY INSURANCE	45,144	45,144	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	44,320		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	239,290		19	3	34	0 **	4,460
4460	BAD DEBTS	18,000		27	3	24	-18,000	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	10,372	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	59,803	65,863	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	6,060		6	1	0	0	4,510
5130	ELECTRIC	38,054	84,096	5	3	0	0	4,600
5131	NATURAL GAS	29,777		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	16,265		5	3	0	0	5,130
5134	TRASH COLLECTION	9,144	59,060	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	15,423	49,010	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	33,587		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	49,916		6	3	0	0	5,140
5210	DIETARY WAGES	162,609	175,557	1	1	0	0	5,160
5220	DIETARY SICK & VAC	12,948		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	196,158	194,708	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,923	11,457	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,634		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	6,900		1	2	0	0	5,260
5295	MEAL CREDIT	-1,450		2	2	0	0	5,270
5310	LAUNDRY WAGES	40,734	43,508	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,774		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	8,371	19,894	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	11,523		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	94,785	103,548	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	8,763		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	29,946	32,979	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	3,033		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,459,686	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	196,263		10	1	0	0	6,020
6030	DON WAGES	64,262		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	16,783		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	396,890		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	25,996		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	701,376		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	58,116		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	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	19,831	82,691	10	2	0	0	7,281
6295	NURSING SUPPLIES	60,151		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	2,709		10	2	0	0	7,391
6490	NURSING OTHER	449	7,595	10	3	0	0	7,393
7280	DRUG PURCHASES	169,741	365,969	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	193,308		39	2			7,540
7380	LABORATORY SERVICES	28,570	654,555	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	35,588	40,078	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,490		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	2,176	2,176	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	246,684		39	3	0	0 ***	7,890
7660	PT SUPPLIES	2,920		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	55,065	58,271	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	3,206		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	309,596		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	69,705		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	10,961	10,961	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	666	666	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	446,760	446,760	34	3	0	0	

8120	INTEREST EXPENSE	21,276	21,276	32	3	14	-9,837	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-9,837		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

5,128,870 5,138,707
9,837

GRAND TOTALS

-408,755 -56,311
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	6,890	6,890
IPA	14,436	14,436
medic	4,318	4,318
		25,644

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3,007 PATIENT	14,436
3,007 PATIENT	4,318
	0
3,010 BASIC CI	(4,910,150)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(18,950)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(714,976)
	0
3,110 PHYSICIAN	(2,160,895)
	0
3,112 PHYSICIAN	0
3,113 PHYSICIAN	0
3,140 LABORATORY INCOME	0
	0
3,152 ST/OT TR	0
3,153 ST/OT TR	0
3,185 REHAB/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	2,196,487

3,520 RENT INC	0
3,530 BEAUTY	(13,109)
	0
3,570 VENDING	(310)
3,590 EQUIPMI	(8,457)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	80,683
4,111 ADMINIS	96,793
4,115 G&A PTC	9,446
4,120 EMPLOY	8,901
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	8,182
4,255 POSTAGI	2,655
4,260 TELEPHC	10,014
4,275 TRAININ	5,590
	0
4,280 GENERA	3,607
4,281 MEAL EX	252
4,285 EDUCAT	619
4,289 MEETING	0
4,290 HELP WA	1,513
4,291 PROMOT	4,788
4,292 PUBLIC I	6,094
4,300 LICENSE	57,014
4,310 DUES & S	5,727
4,320 CONTRIB	50
4,350 PROFESS	6,507
4,355 MEDICAL	28,516
	1,026
	6,120

4,364 SOCIAL S	1,590
4,370 TV RENT	6,459
4,383 BACKGR	1,162
4,390 OTHER T	0
4,400 PAYROL	189,628
4,401 PAYROL	10,047
4,410 GROUP I	241,125
4,420 LIABILIT	45,144
4,430 WORKM	43,398
4,435 W/C-FIRS	0
4,436 DRUG TE	922
4,450 MANAGI	239,290
4,460 BAD DEF	18,000
4,461 BAD DEF	92,735
4,470 LOST ITE	0
4,475 UNIFORM	152
4,486 SERVICE	26,478
4,490 MISC EX	66
4,496 MISC. M.	10,562
4,510 REAL ES	0
4,600 LEASED	3,913
5,110 MAINTEI	59,803
5,120 MAINTEI	6,060
5,130 ELECTRI	38,054
5,131 NATURA	29,777
5,133 WATER &	16,265
5,134 TRASH C	9,144
5,140 PROP/PL	15,423
5,160 GENERA	33,587
5,165 MAINTEI	23,438
5,210 DIETARY	162,609
5,220 DIETARY	12,948
5,248 FOOD PU	196,092

5,250 SUPPLIE	2,923
5,260 REPLACI	1,634
5,270 KITCHEN	6,900
5,295 MEAL IN	(1,450)
5,310 LAUNDR	40,734
5,340 LAUNDR	2,774
5,370 REPLACI	8,371
	0
5,390 SUPPLIE	11,523
5,410 HOUSEK	94,785
5,440 HOUSEK	8,763
5,480 SUPPLIE	29,946
5,490 SUPPLIE	3,033
6,020 RN WAG	196,263
6,030 DON WA	64,262
6,035 ADON W	0
6,040 RN PTO &	16,783
6,120 LPN WAG	396,890
6,140 LPN PTO	25,996
6,220 AIDES W	701,376
6,240 AIDES PT	58,116
6,245	0
	0
	0
	0
6,270 REHAB V	0
6,275 REHAB F	0
6,290 NURSINC	19,831
6,295 NURSINC	60,151
6,390 REPLACI	2,709
6,490 OTHER	449

7,280 DRUG PU	169,741
7,281 DRUG PU	193,308
7,380 LABORA	14,197
7,390 X-RAY S	14,373
	0
7,510 ACTIVIT	35,588
7,540 ACTIVIT	4,490
7,590 ACTIVIT	2,176
7,620 PHYSICA	246,684
7,660 P.T. SUPE	2,920
7,710 SOCIAL S	55,065
7,720 SOCIAL S	3,206
7,730 SOCIAL S	0
7,740 OCCUPA	309,596
7,770 SPEECH '	69,705
7,820 BEAUTIC	10,961
	666
	0
8,120 INTERES	0
	21,276
8,130 DEPRECI	0
	0
9,510 INTERES	(9,837)
9,520 MISC NO	0
4,220	0
8,100	446,760
9,702	0
5,230	0
	<u>(408,755)</u>

Expenses Fixed Assets

