

		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>0041699</u></p> <p>Facility Name: <u>Heritage Health-Springfield</u></p> <p>Address: <u>900 North Rutledge</u> <u>Springfield</u> <u>62702</u> <small>Number City Zip Code</small></p> <p>County: <u>Sangamon</u></p> <p>Telephone Number: <u>(217) 789-0930</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1996</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-Springfield

0041699 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	178	Skilled (SNF)	178	64,970	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	178	TOTALS	178	64,970	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	36,432	14,193	9,418	60,043	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,432	14,193	9,418	60,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.42%

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 1996

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 9,418

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-Springfield

0041699

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	386,118	31,470		417,588		417,588	8,970	426,558		1
2	Food Purchase		445,998		445,998		445,998	107	446,105		2
3	Housekeeping	213,169	74,365		287,534		287,534		287,534		3
4	Laundry	114,556	34,210		148,766		148,766		148,766		4
5	Heat and Other Utilities			243,771	243,771		243,771	2,446	246,217		5
6	Maintenance	154,770	92,317	113,569	360,656		360,656	30,561	391,217		6
7	Other (specify):*										7
8	TOTAL General Services	868,613	678,360	357,340	1,904,313		1,904,313	42,084	1,946,397		8
	B. Health Care and Programs										
9	Medical Director			24,880	24,880		24,880		24,880		9
10	Nursing and Medical Records	3,524,646	288,122	34,753	3,847,521		3,847,521	520	3,848,041		10
10a	Therapy		1,252,587	1,164,573	2,417,160	(1,280,723)	1,136,437		1,136,437		10a
11	Activities	98,489	2,367		100,856		100,856		100,856		11
12	Social Services	67,564		4,894	72,458		72,458		72,458		12
13	CNA Training							1,509	1,509		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,690,699	1,543,076	1,229,100	6,462,875	(1,280,723)	5,182,152	2,029	5,184,181		16
	C. General Administration										
17	Administrative	97,914			97,914		97,914		97,914		17
18	Directors Fees										18
19	Professional Services			456,228	456,228		456,228	(388,156)	68,072		19
20	Dues, Fees, Subscriptions & Promotions			154,083	154,083	(97,455)	56,628	(11,083)	45,545		20
21	Clerical & General Office Expenses	506,783	42,139	78,376	627,298		627,298	550,152	1,177,450		21
22	Employee Benefits & Payroll Taxes			1,090,747	1,090,747		1,090,747	90,549	1,181,296		22
23	Inservice Training & Education			2,595	2,595		2,595	2,688	5,283		23
24	Travel and Seminar			2,978	2,978		2,978	2,021	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			177,063	177,063		177,063	20,269	197,332		26
27	Other (specify):* Lost Resident Items			44,545	44,545		44,545	(43,100)	1,445		27
28	TOTAL General Administration	604,697	42,139	2,006,615	2,653,451	(97,455)	2,555,996	223,340	2,779,336		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,164,009	2,263,575	3,593,055	11,020,639	(1,378,178)	9,642,461	267,453	9,909,914		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			312,411	312,411		312,411	35,957	348,368			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,832	57,832		57,832	(57,479)	353			32
33	Real Estate Taxes			88,258	88,258		88,258		88,258			33
34	Rent-Facility & Grounds							11,310	11,310			34
35	Rent-Equipment & Vehicles			16,871	16,871		16,871	14,309	31,180			35
36	Other (specify):*											36
37	TOTAL Ownership			475,372	475,372		475,372	4,097	479,469			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					1,280,723	1,280,723	(212,734)	1,067,989			39
40	Barber and Beauty Shops			22,380	22,380		22,380		22,380			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,455	97,455		97,455			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			22,380	22,380	1,378,178	1,400,558	(212,734)	1,187,824			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,164,009	2,263,575	4,090,807	11,518,391		11,518,391	58,816	11,577,207			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-Springfield

0041699

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(57,433)			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	(9,748)			17
18	Fines and Penalties				18
19	Entertainment	(12,233)			19
20	Contributions	(100)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(19,539)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,000)			24
25	Fund Raising, Advertising and Promotional	(15,840)			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)	\$ (157,893)		\$	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)	216,709		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 216,709		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 58,816		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-Springfield

ID# 0041699

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		(9,748)	20	17
18				18
19			24	19
20		(100)	27	20
21				21
22		(19,539)	19	22
23				23
24		(43,000)	27	24
25		(15,840)	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		(88,227)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Springfield# 0041699

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	8,970	0	0	0	0	0	0	0	0	8,970	1
2	Food Purchase	0	0	107	0	0	0	0	0	0	0	0	107	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	2,446	0	0	0	0	0	0	0	0	2,446	5
6	Maintenance	0	0	30,561	0	0	0	0	0	0	0	0	30,561	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	42,084	0	0	0	0	0	0	0	0	42,084	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	520	0	0	0	0	0	0	0	0	520	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	1,509	0	0	0	0	0	0	0	0	1,509	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	2,029	0	0	0	0	0	0	0	0	2,029	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	(19,539)	(404,716)	36,099	0	0	0	0	0	0	0	0	(388,156)	19
20	Fees, Subscriptions & Promotions	(25,588)	0	14,505	0	0	0	0	0	0	0	0	(11,083)	20
21	Clerical & General Office Expenses	0	0	550,152	0	0	0	0	0	0	0	0	550,152	21
22	Employee Benefits & Payroll Taxes	0	0	90,549	0	0	0	0	0	0	0	0	90,549	22
23	Inservice Training & Education	0	0	2,688	0	0	0	0	0	0	0	0	2,688	23
24	Travel and Seminar	(12,233)	0	14,254	0	0	0	0	0	0	0	0	2,021	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	20,269	0	0	0	0	0	0	0	0	20,269	26
27	Other (specify):*	(43,100)	0	0	0	0	0	0	0	0	0	0	(43,100)	27
28	TOTAL General Administration	(100,460)	(404,716)	728,516	0	0	0	0	0	0	0	0	223,340	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(100,460)	(404,716)	772,629	0	0	0	0	0	0	0	0	267,453	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Springfield

0041699

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	0	0	35,957	0	0	0	0	0	0	0	35,957	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,433)	0	0	(46)	0	0	0	0	0	0	0	(57,479)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	11,310	0	0	0	0	0	0	0	11,310	34
35	Rent-Equipment & Vehicles	0	0	0	14,309	0	0	0	0	0	0	0	14,309	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(57,433)	0	0	61,530	0	4,097	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	(212,734)	0	0	0	0	0	0	0	0	0	(212,734)	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	(212,734)	0	0	0	0	0	0	0	0	0	(212,734)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(157,893)	(617,450)	772,629	61,530	0	58,816	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
Heritage Enterprises, Inc.	50	Attachment-See Following Page		Heritage Operations Group	Bloomington	Mgmt Svcs
Memorial Health Ventures	50			Green Tree Pharmacy	Minonk	Pharmacy

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
	V		\$			\$		1
	V	39 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(212,734)	(212,734)	2
	V							3
	V	19 Adjustment for Related Organization	404,716	Heritage Operations Group, LLC	0.00%		(404,716)	4
	V							5
	V	34 Adjustment for Related Organization	0	Heritage Manor Real Estate, LLC	0.00%			6
	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
	V							11
	V							12
	V							13
	Total		\$ 404,716			\$ (212,734)	\$ * (617,450)	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.		\$	\$	8,970	15	
16	V	2 Food Purchase						107	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						2,446	19	
20	V	6 Maintenance						30,561	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						520	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,509	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						36,099	31	
32	V	20 Fees, Subscription, Promotions						14,505	32	
33	V	21 Clerical & General Office Expenses						550,152	33	
34	V	22 Employee Benefits & Payroll Taxes						90,549	34	
35	V	23 Inservice Training & Education						2,688	35	
36	V	24 Travel and Seminar						14,254	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						20,269	38	
39	Total		\$			\$	0	\$ *	772,629	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						35,957	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(46)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						11,310	20	
21	V	35 Rent-Equipment & Vehicles						14,309	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	\$ *	61,530	39

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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.	Member		50.00					\$	1
2	Memorial Health Ventures	Member		50.00						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-Springfield

0041699

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	178	\$ 8,970	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	178	107	2
3	3	Housekeeping	Beds	2,666	25	0	0	178	0	3
4	4	Laundry	Beds	2,666	25	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	178	2,446	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	178	30,561	6
7	7	Other	Beds	2,666	25	0	0	178	0	7
8	9	Medical Director	Beds	2,666	25	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	178	520	9
10	11	Activities	Beds	2,666	25	0	0	178	0	10
11	12	Social Service	Beds	2,666	25	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	178	1,509	12
13	14	Program Transportation	Beds	2,666	25	0	0	178	0	13
14	15	Other	Beds	2,666	25	0	0	178	0	14
15	17	Administrative	Beds	2,666	25	0	0	178	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	178	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	178	36,099	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	178	14,505	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	178	550,152	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	178	90,549	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	178	2,688	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	178	14,254	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	178	20,269	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 772,629	25

Facility Name & ID Number Heritage Health-Springfield

0041699 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	\$	178	\$	1
2	30	Depreciation	Beds	2,666	25	538,548	178	35,957	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25		178		3
4	32	Interest	Beds	2,666	25	(682)	178	(46)	4
5	33	Real Estate Taxes	Beds	2,666	25		178		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393	178	11,310	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306	178	14,309	7
8	36	Other	Beds	2,666	25		178		8
9	38	Medically Nec Transportation	Beds	2,666	25		178		9
10	39	Ancillary Service Centers	Beds	2,666	25		178		10
11	40	Barber and Beauty Shops	Beds	2,666	25		178		11
12	41	Coffee and Gift Shops	Beds	2,666	25		178		12
13	42	Other	Beds	2,666	25		178		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	\$		\$ 61,530	25

Facility Name & ID Number

Heritage Health-Springfield

0041699

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		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Bank of Springfield		x	Mortgage			\$	\$ 1,360,598			\$	57,832	1					
2														2					
3														3					
4														4					
5														5					
		Working Capital																	
6														6					
7														7					
8														8					
9		TOTAL Facility Related					\$	\$ 1,360,598			\$	57,832	9						
		B. Non-Facility Related*																	
10		Interest Income											(57,433)	10					
11														11					
12		Allocated Corporate											(46)	12					
13														13					
14		TOTAL Non-Facility Related					\$	\$			\$	(57,479)	14						
15		TOTALS (line 9+line14)					\$	\$ 1,360,598			\$	353	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.		\$	<u>131,997</u>		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.)		\$	<u>117,539</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(14,458)</u>		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>123,416</u>		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 \$ <u>20,700</u> For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(20,700)</u>		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>88,258</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>126,452</u>	8	FOR BHF USE ONLY	
	2010	<u>119,559</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>122,620</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>125,712</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>117,539</u>	12	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-Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041699

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>14280277027</u>	_____	\$ <u>117,539.20</u>	\$ <u>117,539.20</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>117,539.20</u></u>	\$ <u><u>117,539.20</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,805 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4

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>630,000</u>	1
2					2
3	TOTALS			\$ <u>630,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	178			\$ 1,900,000	\$		\$	\$	\$
5				1,648,258					
6									
7									
8									
Improvement Type**									
9	1985 Improvements		1985	26,076					
10	1986 Improvements		1986	216,545					
11	1987 Improvements		1987	593,121					
12	1988 Improvements		1988	29,321					
13	1989 Improvements		1989	1,095					
14	1990 Improvements		1990	939					
15	1991 Improvements		1991	32,022					
16	1992 Improvements		1992	32,593					
17	1993 Improvements		1993	105,986					
18	1994 Improvements		1994	59,542					
19	1995 Improvements		1995	36,126					
20	Laundry Chute		1996	4,926					
21	Door Alarm		1996	8,533					
22	Garbage Disposal		1996	1,113					
23	Elevator		1996	11,439					
24									
25									
26									
27									
28									
29									
30									
31									
32									
33	C/O Allocation				35,957		35,957		
34	Book Depreciation				250,029		250,029		
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-Springfield

0041699

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,668,973	\$ 285,986		\$ 285,986	\$	\$	70

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

Facility Name & ID Number Heritage Health-Springfield# 0041699

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		\$ 5,668,973	\$ 285,986		\$ 285,986	\$	\$	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11									11
12	Door Replacement	2003	1,216						12
13									13
14									14
15	Shower Room Remodel	2003	14,285						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	36,919						19
20	Elevator Repair	2004	74,457						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24	Controller board	2005	2,460						24
25	Wall Railing	2005	2,837						25
26	A/C Protection	2005	1,318						26
27	Compressor	2005	10,800						27
28	Chiller	2005	2,305						28
29	Rooftop Compressor	2005	4,676						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,050,204	\$ 285,986		\$ 285,986	\$	\$	34

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

Facility Name & ID Number Heritage Health-Springfield

0041699

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		\$ 6,050,204	\$ 285,986		\$ 285,986	\$	\$	1
2	Sprinkler system	2006	250,656						2
3	Door Alarm	2006	2,940						3
4	Stair Treads	2006	12,497						4
5	Roof	2006	2,219						5
6	Fire door	2006	6,154						6
7									7
8	HVAC Controls								8
9		2007	12,375						9
10	Sprinkler system	2007							10
11	Circulating pump	2007	12,140						11
12		2007	2,693						12
13	Walk-in freezer	2007							13
14	Fire Alarm	2007	24,013						14
15	Exit Lighting	2007							15
16		2007							16
17	HVAC								17
18		2007	18,080						18
19	Window treatments	2007							19
20		2007	3,431						20
21	Beauty Shop sink, vanity, painting								21
22		2008	1,597						22
23									23
24	HVAC								24
25	Elevator	2009	11,480						25
26	Boiler	2009	53,743						26
27	Asphalt	2009	2,914						27
28		2009	9,138						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,476,274	\$ 285,986		\$ 285,986	\$	\$	34

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

Facility Name & ID Number Heritage Health-Springfield

0041699

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,476,274	\$ 285,986		\$ 285,986	\$	\$	1
2									2
3	Elevator	2010	71,294						3
4	Water storage tank	2010	16,211						4
5	paging system	2010	2,642						5
6	water heater	2010	13,740						6
7	dinning room window	2010	49,757						7
8	fire rated metal	2010	3,921						8
9	Aggregate column	2010	34,550						9
10	boiler	2010	3,255						10
11									11
12	100 gallon water heater	2011	8,958						12
13	Chiller	2011	11,556						13
14	Door & Installation	2011	4,361						14
15	Chiller Fan	2011	3,792						15
16	Smoke detector	2011	3,935						16
17	Sign	2011	3,250						17
18									18
19	Lighting upgrade	2012	17,773						19
20	Nurse Call	2012	5,107						20
21									21
22	Nurse Call System Install- Second Floor	2013	13,536						22
23	Extended Care Wing ALC Controls Installation	2013	25,930						23
24	Fire Alarm CPU Replacement	2013	2,761						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)		\$ 6,772,603	\$ 285,986		\$ 285,986	\$	\$	34

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

Facility Name & ID Number Heritage Health-Springfield

0041699

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,772,603	\$ 285,986		\$ 285,986	\$	\$	1
2	Water Pipe Modification	2014	3,598						2
3	Exhaust Fan Replacement	2014	17,340						3
4	Landscaping - Memorial Gardens	2014	15,385						4
5	Hot Water Heater Replacement	2014	3,565						5
6	Gate Valve Replacement-Boiler	2014	2,928						6
7	Replace Existing Roof System	2014	293,339						7
8	Planning for 2015 Remodeling Project	2014	149,522						8
9	Architect Planning Fee								9
10	Furniture and Fixtures Design Fees								10
11	State Review of Plans								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)		\$ 7,258,280	\$ 285,986		\$ 285,986	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,686,801	\$ 62,382	\$ 62,382	\$		\$	71
72	Current Year Purchases	39,910						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,726,711	\$ 62,382	\$ 62,382	\$		\$	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)	\$ 9,614,991	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 348,368	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 348,368	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-Springfield

0041699

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: \$ 16,871 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-Springfield # 0041699 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? <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	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	\$			\$ 556,337	\$		\$ 556,337	1
2	Licensed Speech and Language Development Therapist		hrs				95,276			95,276	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				481,708	3,116		484,824	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					1,249,471		1,249,471	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						31,252			31,252	13
14	TOTAL			\$			\$ 1,164,573	\$ 1,252,587		\$ 2,417,160	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-Springfield

0041699

Report Period Beginning: 01/01/14

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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	\$ 2,771,861	\$	1
2	Cash-Patient Deposits	17,576		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,159,525		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,076		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,725,684		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,761,722	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	7,363,422		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,765,659		16
17	Accumulated Depreciation (book methods)	(6,143,769)		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)	\$ 3,615,312	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,377,034	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 881,008	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,576		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,416		32
33	Accrued Interest Payable	4,476		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Assessment Tax</u>	135,980		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,162,456	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,360,598		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)	\$ 1,360,598	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,523,054	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,853,980	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,377,034	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,968,216	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,968,216	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,885,764	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)	\$ 1,885,764	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)	\$ 7,853,980	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	\$ 12,089,774	1
2	Discounts and Allowances for all Levels	(5,625,473)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,464,301	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,451,920	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,451,920	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	2,841	12
13	Barber and Beauty Care	25,429	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,411,617	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(7,012)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,432,875	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	57,433	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,433	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(2,374)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (2,374)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,404,155	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,904,313	31
32	Health Care	6,462,875	32
33	General Administration	2,653,451	33
B. Capital Expense			
34	Ownership	475,372	34
C. Ancillary Expense			
35	Special Cost Centers	22,380	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)*	\$ 11,518,391	40
41	Income before Income Taxes (line 30 minus line 40)**	1,885,764	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,885,764	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-Springfield

0041699

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	1,900	2,065	\$ 63,270	\$ 30.64	1
2	Assistant Director of Nursing	6,400	6,957	172,462	24.79	2
3	Registered Nurses	20,112	21,626	561,301	25.95	3
4	Licensed Practical Nurses	42,874	46,101	980,086	21.26	4
5	CNAs & Orderlies	130,461	140,281	1,725,301	12.30	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,394	1,499	22,226	14.83	8
9	Activity Director					9
10	Activity Assistants	8,660	9,312	98,489	10.58	10
11	Social Service Workers	3,765	4,048	67,564	16.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,529	39,278	386,118	9.83	15
16	Dishwashers					16
17	Maintenance Workers	11,110	11,946	154,770	12.96	17
18	Housekeepers	19,411	20,872	213,169	10.21	18
19	Laundry	10,251	11,023	114,556	10.39	19
20	Administrator	1,900	2,080	97,914	47.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,119	24,859	506,783	20.39	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)	317,886	341,947	\$ 5,164,009 *	\$ 15.10	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	24,880		36
37	Medical Records Consultant	1,151		37
38	Nurse Consultant			38
39	Pharmacist Consultant	26,190		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	4,894		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 57,115		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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

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

Facility Name & ID Number Heritage Health-Springfield# 0041699

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. \$ 97,455
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. \$ 2,527
- (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 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg 4 Line #	Adjustment Amount		
1009	PETTY CASH	2,771,861						1,009	1,009 PETTY CASH 2,771,861
1010	CASH IN BANK							1,100	1,100 ACCTS RE 2,159,525
1040	CASH IN BANK-PAYROLL							1,101	1,101 ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	2,159,525						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 87,076
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	87,076						1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES							1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY							1,409	1,409 LAND 630,000
1310	SUPPLIES INVENTORY							1,450	1,450 FURNITURE 1,765,659
1409	LAND	630,000						1,460	(1,587,973)
1450	FURNITURE & EQUIPMENT	1,765,659						1,475	1,475 BUILDING 7,363,422
1460	ACCUM DEPR-FURN & EQUIP	-1,587,973						1,490	1,490 ACCUM DEPR (4,555,796)
1475	BUILDING & IMPROVEMENTS	7,363,422						1,530	1,530 RESIDENT 17,576
1490	ACCUM DEPR-BUILDING	-4,555,796						1,550	1,550 LOAN FEES 0
1530	RESIDENT FUNDS	17,576						1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850 INTERCOMPANY 1,725,684
1560	REAL ESTATE TAX ESCROW							2,010	2,010 ACCOUNTS PAYABLE (881,008)
1575	REIMBURSABLE PURCHASES							2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	1,725,684						2,100	2,100 ACCRUED PAYROLL 0
2010	ACCOUNTS PAYABLE	-881,008						2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	0						2,110	2,110 ACCRUED PAYROLL 0
2110	ACCRUED VACATION PAY	0						2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	0
2125	FICA TAX PAYABLE	0	0	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	(4,476)
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(135,980)
2300	ACCRUED INTEREST PAYABLE	-4,476		2,350	2,350 REAL EST	(123,416)
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-135,980		2,400	2,400 CURRENT PORTION OF LT DEB	
2350	REAL ESTATE TAX PAYABLE	-123,416		2,512	2,512 DUE TO F	(17,576)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	(1,360,598)
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	(5,968,216)
2460	INCOME TAXES PAYABLE				net income	(1,885,764)
2512	DUE TO RESIDENTS	-17,576				
2600	MORTGAGE PAYABLE	-1,360,598			balance	<u>0</u>
2650	EQUIPMENT LOAN PAYABLE					
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-5,968,216				
2970	PROFIT/LOSS FOR PERIOD	-1,885,764				
3007.1	PATIENT DAYS-PRIVATE	14,193				3,007

3007.2	PATIENT DAYS-IPA	36,432						3,007
3007.3	PATIENT DAYS-MEDICARE	9,418						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	-12,020,175	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	-58,260	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	-2,411,617	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-4,451,920	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	5,625,473	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	-25,429		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-245		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-2,596		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-11,339		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	7,320		0	0	0	0		4,110
3600	21 MISC INCOME	-308		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	472,359	506,783	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	97,914	97,914	17	1	0	0		4,120
4115	VACATION & SICK - G&A	34,424		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	29,560	1,090,747	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	42,139	42,139	21	2	0	0		4,275
4260	TELEPHONE	78,376	78,376	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	2,595	2,595	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	2,044	2,978	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	934		24	3	19	-12,233 ***		4,289
4290	HELP WANTED ADVERTISING	11,036	154,083	20	3	0	0 -97,455		4,290
4291	PROMOTIONAL ADVERTISING	2,842		20	3	25	-2,842		4,291
4292	PUBLIC RELATIONS	12,998		20	3	25	-12,998		4,292
4300	LICENSES & FEES	106,198		20	3	17	-3,358		4,300
4310	DUES & SUBSCRIPTIONS	15,871		20	3	17	-6,390		4,310
4320	CONTRIBUTIONS	100		27	3	20	-100		4,320
4350	PROFESSIONAL FEES	51,512	456,228	19	3	22	-19,539		4,350
4355	MEDICAL DIRECTOR	24,880	24,880	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	1,151		10	3	0	0	4,364
4363	PHARMACIST FEES	26,190		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	4,894	4,894	12	3	0	0	4,383
4370	TV RENTAL	5,896		35	3	5	0	4,390
4380	INCOME TAXES		44,545	27	3	26	0	4,400
4383	BACKGROUND CHECKS	5,138		20	3	26	0	4,401
4400	PAYROLL TAXES	476,342		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	10,164		22	3	0	0	4,420
4410	GROUP INSURANCE	496,008		22	3	0	0	4,430
4420	LIABILITY INSURANCE	177,063	177,063	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	78,673		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	404,716		19	3	34	0 **	4,460
4460	BAD DEBTS	43,000		27	3	24	-43,000	4,461
4470	LOST ITEMS-RESIDENTS	1,445		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	88,258	88,258	33	3	0	0	4,486
4600	LEASED EQUIPMENT	10,975	16,871	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	147,106	154,770	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	7,664		6	1	0	0	4,510
5130	ELECTRIC	142,188	243,771	5	3	0	0	4,600
5131	NATURAL GAS	54,135		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	47,448		5	3	0	0	5,130
5134	TRASH COLLECTION	34,174	113,569	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	23,324	92,317	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	68,993		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	79,395		6	3	0	0	5,140
5210	DIETARY WAGES	367,660	386,118	1	1	0	0	5,160
5220	DIETARY SICK & VAC	18,458		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	448,525	445,998	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	5,776	31,470	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	5,926		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	19,768		1	2	0	0	5,260
5295	MEAL CREDIT	-2,527		2	2	0	0	5,270
5310	LAUNDRY WAGES	107,608	114,556	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	6,948		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	22,298	34,210	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	11,912		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	197,102	213,169	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	16,067		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	68,351	74,365	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	6,014		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		3,524,646	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	522,677		10	1	0	0	6,020
6030	DON WAGES	63,270		10	1	0	0	6,030
6035	ADON	172,462		10	1	0	0	6,035
6040	RN SICK & VACATION	38,624		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	917,117		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	62,969		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	1,628,778		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	96,523		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	21,616		10	1	0	0	6,390
6275	REHAB SICK & VAC	610		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	53,667	288,122	10	2	0	0	7,281
6295	NURSING SUPPLIES	199,003		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	35,452		10	2	0	0	7,391
6490	NURSING OTHER	7,412	34,753	10	3	0	0	7,393
7280	DRUG PURCHASES	672,594	1,252,587	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	576,877		39	2			7,540
7380	LABORATORY SERVICES	31,252	1,164,573	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	89,223	98,489	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	9,266		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	2,367	2,367	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	481,708		39	3	0	0 ***	7,890
7660	PT SUPPLIES	3,116		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	62,844	67,564	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	4,720		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	556,337		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	95,276		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	22,380	22,380	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	57,832	57,832	32	3	14	-57,433	
8130	DEPRECIATION	312,411	312,411	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-57,433		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	2,374		0	0	0	0	
		11,463,332	11,518,391					
			55,059					

GRAND TOTALS -1,885,764 -157,893
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	14,193	14,193
IPA	36,432	36,432
medic	9,418	9,418
		60,043

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3,007 PATIENT	36,432
3,007 PATIENT	9,418
	0

3,010 BASIC CI	(12,020,175)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(58,260)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(2,411,617)
	0

3,110 PHYSICIAN	(4,451,920)
	0

3,112 PHYSICIAN	0
3,113 PHYSICIAN	0

3,140 LABORATORY INCOME	0
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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	5,414,792
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3,520 RENT INC	0
3,530 BEAUTY	(25,429)
	(245)
3,570 VENDING	(2,596)
3,590 EQUIPMI	(11,339)
3,595 RESIDEN	7,320
3,600 MISC INC	(308)
4,110 G&A WA	472,359
4,111 ADMINIS	97,914
4,115 G&A PTC	34,424
4,120 EMPLOY	27,457
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	24,771
4,255 POSTAGI	5,242
4,260 TELEPHC	78,376
4,275 TRAININ	2,595
	0
4,280 GENERA	2,044
4,281 MEAL EX	0
4,285 EDUCAT	929
4,289 MEETING	5
4,290 HELP WA	11,036
4,291 PROMOT	2,842
4,292 PUBLIC I	12,998
4,300 LICENSE	106,198
4,310 DUES & S	15,871
4,320 CONTRIE	100
4,350 PROFESS	51,512
4,355 MEDICAL	24,880
	1,151
	26,190

4,364 SOCIAL S	4,894
4,370 TV RENT	5,896
4,383 BACKGR	5,138
4,390 OTHER T	2,374
4,400 PAYROL	476,342
4,401 PAYROL	10,164
4,410 GROUP I	496,008
4,420 LIABILIT	177,063
4,430 WORKM	71,816
4,435 W/C-FIRS	2,685
4,436 DRUG TE	4,172
4,450 MANAGI	404,716
4,460 BAD DEF	43,000
4,461 BAD DEF	210,681
4,470 LOST ITE	1,445
4,475 UNIFORM	2,103
4,486 SERVICE	39,550
4,490 MISC EX	1,308
4,496 MISC. M.	12,126
4,510 REAL ES	88,258
4,600 LEASED	10,975
5,110 MAINTEI	147,106
5,120 MAINTEI	7,664
5,130 ELECTRI	142,188
5,131 NATURA	54,135
5,133 WATER &	47,448
5,134 TRASH C	34,174
5,140 PROP/PL	23,324
5,160 GENERA	68,993
5,165 MAINTEI	39,845
5,210 DIETARY	367,660
5,220 DIETARY	18,458
5,248 FOOD PU	447,217

5,250 SUPPLIE	5,776
5,260 REPLACI	5,926
5,270 KITCHEN	19,768
5,295 MEAL IN	(2,527)
5,310 LAUNDR	107,608
5,340 LAUNDR	6,948
5,370 REPLACI	22,298
	0
5,390 SUPPLIE	11,912
5,410 HOUSEK	197,102
5,440 HOUSEK	16,067
5,480 SUPPLIE	68,351
5,490 SUPPLIE	6,014
6,020 RN WAG	522,677
6,030 DON WA	63,270
6,035 ADON W	172,462
6,040 RN PTO &	38,624
6,120 LPN WAG	917,117
6,140 LPN PTO	62,969
6,220 AIDES W	1,628,778
6,240 AIDES PT	96,523
6,245	0
	0
	0
	0
6,270 REHAB V	21,616
6,275 REHAB F	610
6,290 NURSINC	53,667
6,295 NURSINC	199,003
6,390 REPLACI	35,452
6,490 OTHER	7,412

7,280 DRUG PU	672,594
7,281 DRUG PU	576,877
7,380 LABORA	23,657
7,390 X-RAY S	7,595
	0
7,510 ACTIVIT	89,223
7,540 ACTIVIT	9,266
7,590 ACTIVIT	2,367
7,620 PHYSICA	481,708
7,660 P.T. SUPE	3,116
7,710 SOCIAL S	62,844
7,720 SOCIAL S	4,720
7,730 SOCIAL S	0
7,740 OCCUPA	556,337
7,770 SPEECH '	95,276
7,820 BEAUTIC	22,380
	0
	0
8,120 INTERES	0
	57,832
8,130 DEPRECI	312,411
	0
9,510 INTERES	(57,433)
9,520 MISC NO	0
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(1,885,764)</u>

Expenses Fixed Assets

