

Facility Name & ID Number St Claras Manor

0050724 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	140	Skilled (SNF)	140	51,100	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	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	23,190	10,517	2,345	36,052	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,190	10,517	2,345	36,052	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.55%

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 2010

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 2,345

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	287,960	16,621		304,581		304,581	304,581			1
2	Food Purchase		287,772		287,772		287,772	287,772			2
3	Housekeeping	152,288	29,830		182,118		182,118	182,118			3
4	Laundry	56,698	18,795		75,493		75,493	75,493			4
5	Heat and Other Utilities			105,879	105,879		105,879	105,879			5
6	Maintenance	43,092	70,370	82,691	196,153		196,153	196,153			6
7	Other (specify):*										7
8	TOTAL General Services	540,038	423,388	188,570	1,151,996		1,151,996	1,151,996			8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600	3,600			9
10	Nursing and Medical Records	1,840,975	168,940	157,911	2,167,826		2,167,826	2,167,826			10
10a	Therapy		149,438	648,385	797,823	(197,333)	600,490	600,490			10a
11	Activities	63,285	5,438		68,723		68,723	68,723			11
12	Social Services	41,973		3,266	45,239		45,239	45,239			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,946,233	323,816	813,162	3,083,211	(197,333)	2,885,878	2,885,878			16
	C. General Administration										
17	Administrative	75,191			75,191		75,191	75,191			17
18	Directors Fees										18
19	Professional Services			273,461	273,461		273,461	(13,002)	260,459		19
20	Dues, Fees, Subscriptions & Promotions			129,640	129,640	(76,650)	52,990	(32,955)	20,035		20
21	Clerical & General Office Expenses	160,486	23,881	6,712	191,079		191,079	191,079			21
22	Employee Benefits & Payroll Taxes			834,278	834,278		834,278	834,278			22
23	Inservice Training & Education			3,361	3,361		3,361	3,361			23
24	Travel and Seminar			5,523	5,523		5,523	(524)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			76,870	76,870		76,870	76,870			26
27	Other (specify):* Lost Resident Items			60,534	60,534		60,534	(59,100)	1,434		27
28	TOTAL General Administration	235,677	23,881	1,390,379	1,649,937	(76,650)	1,573,287	(105,581)	1,467,706		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,721,948	771,085	2,392,111	5,885,144	(273,983)	5,611,161	(105,581)	5,505,580		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

St Claras Manor

#0050724

Report Period Beginning:

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Ending:

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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											30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(11,971)	(11,971)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			459,900	459,900		459,900		459,900			34
35	Rent-Equipment & Vehicles			1,293	1,293		1,293		1,293			35
36	Other (specify):*											36
37	TOTAL Ownership			461,193	461,193		461,193	(11,971)	449,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					197,333	197,333		197,333			39
40	Barber and Beauty Shops			15,529	15,529		15,529		15,529			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					76,650	76,650		76,650			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			15,529	15,529	273,983	289,512		289,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,721,948	771,085	2,868,833	6,361,866		6,361,866	(117,552)	6,244,314			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 St Claras Manor

0050724

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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	(11,971)			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	(5,517)			17
18	Fines and Penalties				18
19	Entertainment	(524)			19
20	Contributions	(100)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,002)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,000)			24
25	Fund Raising, Advertising and Promotional	(27,438)			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)	\$ (117,552)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (117,552)		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

St Claras Manor

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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		(5,517)	20	17
18				18
19			24	19
20		(100)	27	20
21				21
22		(13,002)	19	22
23				23
24		(59,000)	27	24
25		(27,438)	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		(105,057)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Claras Manor

0050724

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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	(13,002)	0	0	0	0	0	0	0	0	0	0	(13,002)	19
20	Fees, Subscriptions & Promotions	(32,955)	0	0	0	0	0	0	0	0	0	0	(32,955)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(524)	0	0	0	0	0	0	0	0	0	0	(524)	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(59,100)	0	0	0	0	0	0	0	0	0	0	(59,100)	27
28	TOTAL General Administration	(105,581)	0	(105,581)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,581)	0	(105,581)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Claras Manor# 0050724

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	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,971)	0	0	0	0	0	0	0	0	0	0	(11,971)	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	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,971)	0	0	0	0	0	0	0	0	0	0	(11,971)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(117,552)	0	0	0	0	0	0	0	0	0	0	(117,552)	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
NFP						

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Board of Directors List Attached							2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	None								\$	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

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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 _____
 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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

St Claras Manor

0050724

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Ending:

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10	Interest Income										(11,971)					
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			(11,971)					
15	TOTALS (line 9+line14)						\$	\$			(11,971)					

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

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 St Claras Manor COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0050724

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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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 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 St Claras Manor

0050724 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,286 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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>38,660</u>	1
2					2
3	TOTALS			\$ <u>38,660</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	140				\$ 1,624,882	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	1976		1976		65,361					
10	1978		1978		3,451					
11	1980		1980		8,793					
12	1981		1981		11,439					
13	1982		1982		3,826					
14	1983		1983		1,535					
15	1984		1984		4,031					
16	1985		1985		7,859					
17	1986		1986		2,541					
18	1987		1987		10,753					
19	1988		1988		1,006					
20	1989		1989		1,431					
21	1991		1991		8,799					
22	1992		1992		17,963					
23	1993		1993		15,564					
24	1994		1994		51,022					
25	1995		1995		124,932					
26	1996		1996		102,380					
27	1997		1997		39,247					
28	Fire Sprinkler		1998		22,151					
29	Transfer Switch		1998		4,819					
30	Water Line		1998		6,379					
31	Soffits		1998		3,950					
32	Generator		1998		3,164					
33	Heating, A/C Improvements		1998		8,664					
34										
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

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	Windows	1998	\$ 3,422	\$		\$	\$	\$	37
38	Sidewalks	1998	2,963						38
39	Fixtures	1999	224						39
40	Faucets	1999	1,532						40
41	Water System Improvements	1999	7,920						41
42	Windows	1999	23,400						42
43	Fixtures	1999	2,812						43
44	Faucets	1999	1,404						44
45	Heating & Cooling Unit	2000	4,050						45
46	Water System	2000	37,203						46
47	Glass Doors	2000	1,145						47
48	Remodeling	2000	4,581						48
49	Plumbing	2000	4,128						49
50	Windows	2000	600						50
51	Plumbing	2000	1,702						51
52	4 Ton Condensing Unit	2000	4,453						52
53	Windows	2000	5,400						53
54	Exhaust Fan	2000	1,100						54
55	Heating & Cooling Units	2000	4,050						55
56	Doors	2000	4,081						56
57	Porch Ceiling	2000	4,050						57
58	Exhaust Fan	2000	2,046						58
59	Concrete Pad	2000	5,398						59
60	Fire Sprinkler	2001	1,304						60
61	Faucets	2001	3,432						61
62	Patio Roof	2001	1,532						62
63	Exhaust Fan	2001	1,000						63
64	A/C Unit	2001	16,312						64
65	A/C Kitchen	2001	6,850						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,314,036	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,314,036	\$		\$	\$	\$	1
2									2
3	Code Alert Alarm	2002	5,600						3
4	Ceiling Fan	2002	996						4
5	Heat Cool Units	2002	4,550						5
6	Carpet	2002	2,361						6
7	Seal Coat Parking Lot	2002	3,342						7
8	Walk-In Cooler	2002	17,518						8
9	Roof Replacement	2002	92,577						9
10	Door	2002	824						10
11	Wide Area Network Wiring	2002	3,167						11
12									12
13	Roof Replacement	2003	53,524						13
14	Facility Wiring	2003	11,041						14
15	Remodel Bathrooms	2003	33,616						15
16	Closet Doors	2003	4,188						16
17	Water Heaters and Storage Tank	2003	38,929						17
18	Capital Report Adj	2003	(10,796)						18
19	Furnace	2004	1,800						19
20	Remodel Activity room-- carpet	2004	2,624						20
21	Heat Cool Units	2004	8,094						21
22	Remodel Employee Lounge	2004	2,955						22
23	Electric Door opener	2004	1,598						23
24	Drain Grate	2004	2,350						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,594,894	\$		\$	\$	\$	34

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

Facility Name & ID Number St Claras Manor

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,594,894	\$		\$	\$	\$	1
2									2
3	Code Alert System	2005	726						3
4	Kitchen Hood	2005	1,662						4
5	Wander System	2005	2,543						5
6	Hallway remode -- Paint and carpet	2005	20,919						6
7	A/C Units	2005	1,187						7
8	Fire Supression	2005	1,845						8
9									9
10	A/C Units	2006	1,843						10
11	Security Camera	2006	1,059						11
12	PTAC Units	2006	1,287						12
13	A/C Units	2006	1,207						13
14									14
15									15
16									16
17	Simplex Fire Alarm	2008	8,105						17
18									18
19	Otis elevator	2008	183,160						19
20	Fire Alarm	2008	18,587						20
21									21
22	Fire Sprinkler	2009	4,477						22
23									23
24	Masonry --building exterior	2010	11,260						24
25									25
26	Water heater & conditioner	2011	19,115						26
27	Roof	2011	88,421						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,962,297	\$		\$	\$	\$	34

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

Facility Name & ID Number St Claras Manor

0050724

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		\$ 2,962,297	\$		\$	\$	\$	1
2									2
3	Rooftop Heating & Cooling Unit	2013	21,000						3
4	Lighting Retrofit	2013	4,482						4
5	Water Temperature Control & Mixing Valve	2013	4,370						5
6	A/C Unit	2013	2,540						6
7	Sprinkler Installation-Exterior Canopies	2013	5,580						7
8									8
9	New Generator	2014	43,875						9
10	Installation of Electrical Outlets	2014	4,432						10
11	Replace Condensing Unit	2014	4,528						11
12	Upgrade Tankless Water Heater	2014	26,198						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)		\$ 3,079,302	\$		\$	\$	\$	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	\$ 1,271,557	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,271,557	\$	\$	\$		\$	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)	\$ 4,389,519	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	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

St Claras Manor

0050724

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: St. Clara's Senior Services

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:				\$ 459,900			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 459,900			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	\$ 459,900
-----------------	------------

13. _____ /2016	\$ 459,900
-----------------	------------

14. _____ /2017	\$ 459,900
-----------------	------------

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 _____.

_____ 0

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: \$ 1,293 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input 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	\$			\$ 216,360	\$		\$ 216,360	1
2	Licensed Speech and Language Development Therapist		hrs				124,772			124,772	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				258,496	862		259,358	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					148,576		148,576	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						48,757			48,757	13
14	TOTAL			\$			\$ 648,385	\$ 149,438		\$ 797,823	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 St Claras Manor

0050724

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 915,436	\$	1
2	Cash-Patient Deposits	25,259		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,265,967		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,290		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	435,709		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,689,661	\$	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)	\$ 2,689,661	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 198,700	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,259		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	281,199		30
31	Accrued Taxes Payable (excluding real estate taxes)	(30,101)		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>Bed Tax</u>	84,725		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 559,782	\$	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)	\$ 559,782	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,129,879	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,689,661	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,341,307	1
2	Restatements (describe):		2
3	Audit Reclassifications	(94,357)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,246,950	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(117,071)	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)	\$ (117,071)	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)	\$ 2,129,879	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 5,514,636	1	
2	Discounts and Allowances for all Levels	(1,818,253)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,696,383	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,255,872	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,255,872	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	437	12	
13	Barber and Beauty Care	17,719	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	249,907	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	(1,191)	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 266,872	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	25,668	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,668	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,244,795	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,151,996	31	
32	Health Care	3,083,211	32	
33	General Administration	1,649,937	33	
B. Capital Expense				
34	Ownership	461,193	34	
C. Ancillary Expense				
35	Special Cost Centers	15,529	35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,361,866	40	
41	Income before Income Taxes (line 30 minus line 40)**	(117,071)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (117,071)	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? Yes 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 St Claras Manor

0050724

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	1,742	1,936	\$ 67,559	\$ 34.90	1
2	Assistant Director of Nursing	1,634	1,816	50,055	27.56	2
3	Registered Nurses	8,014	8,904	266,167	29.89	3
4	Licensed Practical Nurses	22,920	25,467	602,845	23.67	4
5	CNAs & Orderlies	58,261	64,735	794,045	12.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,035	2,261	60,304	26.67	8
9	Activity Director					9
10	Activity Assistants	5,394	5,993	63,285	10.56	10
11	Social Service Workers	1,777	1,975	41,973	21.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,815	27,572	287,960	10.44	15
16	Dishwashers					16
17	Maintenance Workers	2,979	3,310	43,092	13.02	17
18	Housekeepers	11,488	12,765	152,288	11.93	18
19	Laundry	4,913	5,459	56,698	10.39	19
20	Administrator	1,872	2,080	75,191	36.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,721	7,468	160,486	21.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,565	171,741	\$ 2,721,948 *	\$ 15.85	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	3,600		36
37	Medical Records Consultant	4,153		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,180		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,266		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,199		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 3,245		50
51	Licensed Practical Nurses	11,205		51
52	Certified Nurse Assistants/Aides	132,803		52
53	TOTAL (lines 50 - 52)	\$ 147,253		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		
Mike Eads			\$ 75,191	Workers' Compensation Insurance	\$ 76,576	IDPH License Fee	\$		
				Unemployment Compensation Insurance	16,301	Advertising: Employee Recruitment	10,237		
				FICA Taxes	208,229	Health Care Worker Background Check (Indicate # of checks performed _____)	2,200		
				Employee Health Insurance	495,208	Patient Background Checks			
				Employee Meals		PR	10,638		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,140		
				Other Benefits	37,964	License & Fees	975		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	(10,638)		
						Non-allowable advertising	(5,517)		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,035		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description				Amount					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Heritage Operations Group	Mgt		\$ 249,157				Out-of-State Travel	\$	
Principal	Financial Svcs		500						
Versight	Benefits		2,782						
JM Abbott	Audit		7,600				In-State Travel		
AUL	Retirement		250					3,457	
ADP	Payroll		1,015					19	
							Seminar Expense	2,047	
								(524)	
							Entertainment Expense	()	
Legal adj to Zero			12,157				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL				TOTAL	\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

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

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,650
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,012
- (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: JM Abbott & Co
- (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	915,436						1,009	1,009	PETTY CASH 915,436
1010	CASH IN BANK							1,100	1,100	ACCTS RECEIVABLE 1,265,967
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	1,265,967						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 47,290
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	47,290						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	FURNITURE 0
1409	LAND	0						1,460		0
1450	FURNITURE & EQUIPMENT	0						1,475	1,475	BUILDING 0
1460	ACCUM DEPR-FURN & EQUIP	0						1,490	1,490	ACCUM DEPR-BUILDING 0
1475	BUILDING & IMPROVEMENTS	0						1,530	1,530	RESIDENT FUNDS 25,259
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FEES 0
1530	RESIDENT FUNDS	25,259						1,551	1,551	LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850	INTERCOMPANY 435,709
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUNTS PAYABLE (198,700)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
1850	INTRACOMPANY	435,709						2,100	2,100	ACCRUED PAYROLL (138,818)
2010	ACCOUNTS PAYABLE	-198,700						2,100	2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-138,818						2,110	2,110	ACCRUED PAYROLL (142,381)
2110	ACCRUED VACATION PAY	-142,381						2,120	2,120	U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	30,101
2125	FICA TAX PAYABLE	30,101	30,101	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 EMPLOYEEE 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	(84,725)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-84,725		2,400	2,400 CURRENT PORTION OF LT DEB	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(25,259)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	(2,246,950)
2460	INCOME TAXES PAYABLE				net income	117,071
2512	DUE TO RESIDENTS	-25,259				
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	-2,246,950				
2970	PROFIT/LOSS FOR PERIOD	117,071				
3007.1	PATIENT DAYS-PRIVATE	10,517				3,007

3007.2	PATIENT DAYS-IPA	23,190						3,007
3007.3	PATIENT DAYS-MEDICARE	2,345						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE & VA	-5,500,191	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	-13,846	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	-249,907	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,255,872	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	1,818,253	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	-17,719		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-437		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-599		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	1,191		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	149,312	160,486	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	75,191	75,191	17	1	0	0		4,120
4115	VACATION & SICK - G&A	11,174		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	37,964	834,278	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	23,881	23,881	21	2	0	0		4,275
4260	TELEPHONE	6,712	6,712	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	3,361	3,361	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	3,457	5,523	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	19		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	2,047		24	3	19	-524 ***		4,289
4290	HELP WANTED ADVERTISING	10,237	129,640	20	3	0	0 -76,650		4,290
4291	PROMOTIONAL ADVERTISING	16,800		20	3	25	-16,800		4,291
4292	PUBLIC RELATIONS	10,638		20	3	25	-10,638		4,292
4300	LICENSES & FEES	77,625		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	12,140		20	3	17	-5,517		4,310
4320	CONTRIBUTIONS	100		27	3	20	-100		4,320
4350	PROFESSIONAL FEES	24,696	273,461	19	3	22	-13,002		4,350
4355	MEDICAL DIRECTOR	3,600	3,600	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	4,153		10	3	0	0	4,364
4363	PHARMACIST FEES	6,180		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,266	3,266	12	3	0	0	4,383
4370	TV RENTAL	729		35	3	5	0	4,390
4380	INCOME TAXES		60,534	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,200		20	3	26	0	4,401
4400	PAYROLL TAXES	216,725		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	7,805		22	3	0	0	4,420
4410	GROUP INSURANCE	495,208		22	3	0	0	4,430
4420	LIABILITY INSURANCE	76,870	76,870	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	76,576		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	248,765		19	3	34	0 **	4,460
4460	BAD DEBTS	59,000		27	3	24	-59,000	4,461
4470	LOST ITEMS-RESIDENTS	1,434		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	564	1,293	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	40,984	43,092	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	2,108		6	1	0	0	4,510
5130	ELECTRIC	59,956	105,879	5	3	0	0	4,600
5131	NATURAL GAS	14,084		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	31,839		5	3	0	0	5,130
5134	TRASH COLLECTION	11,492	82,691	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	8,648	70,370	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	61,722		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	71,199		6	3	0	0	5,140
5210	DIETARY WAGES	273,737	287,960	1	1	0	0	5,160
5220	DIETARY SICK & VAC	14,223		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	292,784	287,772	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	5,421	16,621	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,580		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,620		1	2	0	0	5,260
5295	MEAL CREDIT	-5,012		2	2	0	0	5,270
5310	LAUNDRY WAGES	52,312	56,698	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,386		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	12,779	18,795	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	6,016		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	141,600	152,288	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	10,688		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	25,225	29,830	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	4,605		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,840,975	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	249,861		10	1	0	0	6,020
6030	DON WAGES	67,559		10	1	0	0	6,030
6035	ADON	50,055		10	1	0	0	6,035
6040	RN SICK & VACATION	16,306		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	569,330		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	33,515		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	754,204		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	39,841		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	3,245		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	11,205		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	132,803		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	56,312		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,992		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	142,211	168,940	10	2	0	0	7,281
6295	NURSING SUPPLIES	4,412		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	22,317		10	2	0	0	7,391
6490	NURSING OTHER	325	157,911	10	3	0	0	7,393
7280	DRUG PURCHASES	148,576	149,438	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	0		39	2			7,540
7380	LABORATORY SERVICES	48,757	648,385	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	60,030	63,285	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	3,255		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	5,438	5,438	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	258,496		39	3	0	0 ***	7,890
7660	PT SUPPLIES	862		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	38,686	41,973	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	3,287		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	216,360		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	124,772		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	15,529	15,529	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	459,900	459,900	34	3	0	0	

8120	INTEREST EXPENSE	0	0	32	3	14	-11,971	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-11,971		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	-13,697		0	0	0	0	

6,336,198 6,361,866
25,668

GRAND TOTALS 117,071 -117,552
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	10,517	10,517
IPA	23,190	23,190
medic	2,345	2,345
		36,052

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3,007 PATIENT	23,190
3,007 PATIENT	2,345
	0
3,010 BASIC CI	(5,500,191)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(13,846)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(249,907)
	0
3,110 PHYSICIAN	(2,255,872)
	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 REHABILITATION/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	1,712,665

3,520 RENT INC	0
3,530 BEAUTY	(17,719)
	0
3,570 VENDING	(437)
3,590 EQUIPMI	(599)
3,595 RESIDEN	1,191
3,600 MISC INC	0
4,110 G&A WA	149,312
4,111 ADMINIS	75,191
4,115 G&A PTC	11,174
4,120 EMPLOY	37,899
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	7,104
4,255 POSTAGI	2,314
4,260 TELEPHC	6,712
4,275 TRAININ	3,361
	0
4,280 GENERA	3,457
4,281 MEAL EX	19
4,285 EDUCAT	1,048
4,289 MEETING	999
4,290 HELP WA	10,237
4,291 PROMOT	16,800
4,292 PUBLIC I	10,638
4,300 LICENSE	77,625
4,310 DUES & :	12,140
4,320 CONTRIE	100
4,350 PROFESS	24,696
4,355 MEDICAL	3,600
	4,153
	6,180

4,364 SOCIAL S	3,266
4,370 TV RENT	729
4,383 BACKGR	2,200
4,390 OTHER T	0
4,400 PAYROL	216,725
4,401 PAYROL	7,805
4,410 GROUP I	495,208
4,420 LIABILIT	76,870
4,430 WORKM	74,043
4,435 W/C-FIRS	632
4,436 DRUG TE	1,901
4,450 MANAGI	248,765
4,460 BAD DEF	59,000
4,461 BAD DEF	105,588
4,470 LOST ITE	1,434
4,475 UNIFORM	65
4,486 SERVICE	24,633
4,490 MISC EX	856
4,496 MISC. M.	14,463
4,510 REAL ES	0
4,600 LEASED	564
5,110 MAINTEI	40,984
5,120 MAINTEI	2,108
5,130 ELECTRI	59,956
5,131 NATURA	14,084
5,133 WATER &	31,839
5,134 TRASH C	11,492
5,140 PROP/PL	8,648
5,160 GENERA	61,722
5,165 MAINTEI	46,566
5,210 DIETARY	273,737
5,220 DIETARY	14,223
5,248 FOOD PU	291,928

5,250 SUPPLIE	5,421
5,260 REPLACI	3,580
5,270 KITCHEN	7,620
5,295 MEAL IN	(5,012)
5,310 LAUNDR	52,312
5,340 LAUNDR	4,386
5,370 REPLACI	12,779
	0
5,390 SUPPLIE	6,016
5,410 HOUSEK	141,600
5,440 HOUSEK	10,688
5,480 SUPPLIE	25,225
5,490 SUPPLIE	4,605
6,020 RN WAG	249,861
6,030 DON WA	67,559
6,035 ADON W	50,055
6,040 RN PTO &	16,306
6,120 LPN WAG	569,330
6,140 LPN PTO	33,515
6,220 AIDES W	754,204
6,240 AIDES PT	39,841
	3,245
	11,205
	132,803
	0
	0
	0
6,270 REHAB V	56,312
6,275 REHAB F	3,992
6,290 NURSINC	142,211
6,295 NURSINC	4,412
6,390 REPLACI	22,317
6,490 OTHER	325

7,280 DRUG PU	148,576
7,281 DRUG PU	0
7,380 LABORA	20,352
7,390 X-RAY S	28,405
	0
7,510 ACTIVIT	60,030
7,540 ACTIVIT	3,255
7,590 ACTIVIT	5,438
7,620 PHYSICA	258,496
7,660 P.T. SUPE	862
7,710 SOCIAL S	38,686
7,720 SOCIAL S	3,287
7,730 SOCIAL S	0
7,740 OCCUPA	216,360
7,770 SPEECH'	124,772
7,820 BEAUTIC	15,529
	0
	0
8,120 INTERES	0
	0
8,130 DEPRECI	0
	0
9,510 INTERES	(11,971)
9,520 MISC NO	(13,697)
4,220	0
8,100	459,900
9,702	0
5,230	0
	<u>117,071</u>

Expenses Fixed Assets

