



Facility Name & ID Number Country Health

# 0007880 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	89	Skilled (SNF)	89	32,485	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	89	TOTALS	89	32,485	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	10,946	16,849	2,348	30,143	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,946	16,849	2,348	30,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.79%

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 1970

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 2,348

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 &amp; ID Number

Country Health

# 0007880

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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
	<b>A. General Services</b>										
1	Dietary	233,196	20,738		253,934		253,934		253,934		1
2	Food Purchase		223,501		223,501		223,501		223,501		2
3	Housekeeping	113,088	26,579		139,667		139,667		139,667		3
4	Laundry	65,719	11,112		76,831		76,831		76,831		4
5	Heat and Other Utilities			197,849	197,849		197,849		197,849		5
6	Maintenance	82,630	55,966	66,188	204,784		204,784		204,784		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	494,633	337,896	264,037	1,096,566		1,096,566		1,096,566		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	1,936,407	127,782	7,310	2,071,499		2,071,499		2,071,499		10
10a	Therapy		195,523	512,823	708,346	(231,602)	476,744		476,744		10a
11	Activities	68,055	4,500		72,555		72,555		72,555		11
12	Social Services	37,064		3,295	40,359		40,359		40,359		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,041,526	327,805	536,628	2,905,959	(231,602)	2,674,357		2,674,357		16
	<b>C. General Administration</b>										
17	Administrative	84,932			84,932		84,932		84,932		17
18	Directors Fees										18
19	Professional Services			201,274	201,274		201,274	(4,576)	196,698		19
20	Dues, Fees, Subscriptions & Promotions			93,447	93,447	(48,728)	44,719	(29,629)	15,090		20
21	Clerical & General Office Expenses	206,054	20,873	7,567	234,494		234,494		234,494		21
22	Employee Benefits & Payroll Taxes			636,645	636,645		636,645		636,645		22
23	Inservice Training & Education			6,829	6,829		6,829		6,829		23
24	Travel and Seminar			7,030	7,030		7,030	(2,031)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			141,173	141,173		141,173		141,173		26
27	Other (specify):* <b>Lost Items-Residents</b>			22,968	22,968		22,968	(22,954)	14		27
28	<b>TOTAL General Administration</b>	290,986	20,873	1,116,933	1,428,792	(48,728)	1,380,064	(59,190)	1,320,874		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,827,145	686,574	1,917,598	5,431,317	(280,330)	5,150,987	(59,190)	5,091,797		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	
	<b>D. Ownership</b>											
30	Depreciation			357,965	357,965		357,965		357,965			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			268,745	268,745		268,745	(11,140)	257,605			32
33	Real Estate Taxes			269,499	269,499		269,499		269,499			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,950	21,950		21,950		21,950			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			918,159	918,159		918,159	(11,140)	907,019			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					231,602	231,602		231,602			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>					280,330	280,330		280,330			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,827,145	686,574	2,835,757	6,349,476		6,349,476	(70,330)	6,279,146			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 Country Health

# 0007880

Report Period Beginning:

01/01/15

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12/31/15

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	(11,140)			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				17
18	Fines and Penalties				18
19	Entertainment	(2,031)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,576)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,954)			24
25	Fund Raising, Advertising and Promotional	(29,629)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (70,330)</b>		<b>\$</b>	<b>30</b>

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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (70,330)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Country Health

Report Period Beginning: 01/01/15  
 Ending: 12/31/15

ID# 0007880

Sch. V Line  
Reference

NON-ALLOWABLE EXPENSES

Amount

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		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,576)	19	22
23				23
24		(22,954)	27	24
25		(29,629)	20	25
26				26
27		0	22	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	<b>Total</b>		(57,159)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Health

# 0007880

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(4,576)	0	0	0	0	0	0	0	0	0	0	(4,576)	19
20	Fees, Subscriptions & Promotions	(29,629)	0	0	0	0	0	0	0	0	0	0	(29,629)	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	(2,031)	0	0	0	0	0	0	0	0	0	0	(2,031)	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):*	(22,954)	0	0	0	0	0	0	0	0	0	0	(22,954)	27
28	<b>TOTAL General Administration</b>	<b>(59,190)</b>	<b>0</b>	<b>(59,190)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(59,190)</b>	<b>0</b>	<b>(59,190)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Country Health

# 0007880

Report Period Beginning:

01/01/15 Ending:

12/31/15

## 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)	
	<b>D. Ownership</b>													
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	(11,140)	0	0	0	0	0	0	0	0	0	0	(11,140)	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	<b>TOTAL Ownership</b>	<b>(11,140)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,140)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(70,330)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(70,330)</b>	<b>45</b>

**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				Pleasant View	Gifford	Apartments

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)	
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	<b>Total</b>			\$			\$	\$ *	14

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

Facility Name & ID Number

Country Health

# 0007880

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

Facility Name & ID Number      Country Health      #      **0007880**      Report Period Beginning:      01/01/15      Ending:      12/31/15

## 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

Facility Name & ID Number Country Health

# 0007880 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	<b>TOTALS</b>				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	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			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	United Community		x				\$	\$ 6,459,577			\$ 268,745 1					
2											2					
3	EIEC		x					519,398			3					
4											4					
5											5					
<b>Working Capital</b>																
6											6					
7											7					
8											8					
9	<b>TOTAL Facility Related</b>						\$	\$ 6,978,975			\$ 268,745 9					
<b>B. Non-Facility Related*</b>																
10	Interest Income										(11,140) 10					
11											11					
12											12					
13											13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (11,140) 14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 6,978,975			\$ 257,605 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2014 report.		\$	<b>266,454</b>		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.)		\$	<b>261,442</b>		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(5,012)</b>		3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>274,511</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>269,499</b>		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	_____	8	<b>FOR BHF USE ONLY</b>		
	2011	_____	9			
	2012	_____	10			
	2013	<b>311,628</b>	11			
	2014	<b>316,016</b>	12			
<b>Exemption request not filed as Board determined that current Illinois case law does not support renewal of the real estate tax exemption. Board has decided to appeal the valuation. Notice from Illinois Property Tax Appeal Board is attached.</b>				13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

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

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Health COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0007880

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 2014 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 2014.

	(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>110436300003</u>	_____	\$ <u>316,015.56</u>	\$ <u>261,442.00</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u><u>316,015.56</u></u>	\$ <u><u>261,442.00</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?      x   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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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: 58,148 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Pleasant View Apartments - common ownership - 14 independent living units - 12,138 square feet

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				\$ 27,031	1
2					2
3	TOTALS			\$ 27,031	3

Facility Name & ID Number Country Health

**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	89			\$ 744,720	\$		\$	\$	4
5									5
6									6
7									7
8									8
<b>Improvement Type**</b>									
9	1976 Improvements	1976		10,703					9
10	1977 Improvements	1979		15,361					10
11	1978 Improvements	1977		25,766					11
12	1979 Improvements	1978		6,618					12
13	1980 Improvements	1980		30,846					13
14	1981 Improvements	1981		18,567					14
15	1982 Improvements	1982		4,662					15
16	1983 Improvements	1983		28,833					16
17	1984 Improvements	1984		6,700					17
18	1985 Improvements	1985		33,953					18
19	1986 Improvements	1986		23,775					19
20	1987 Improvements	1987		40,603					20
21	1988 Improvements	1988		163,565					21
22	1989 Improvements	1989		50,581					22
23	1990 Improvements	1990		111,695					23
24	1991 Improvements	1991		36,516					24
25	1992 Improvements	1992		26,816					25
26	1993 Improvements	1993		21,383					26
27	1994 Improvements	1994		12,384					27
28	1995 Improvements	1995		5,450					28
29	NURSE CALL SYSTEM	1996		6,349					29
30	DINNING ROOM EXPANSION	1996		10,109					30
31	Dinning Room Remodel	1997		6,121					31
32									32
33									33
34	C/O Allocation								34
35	Book Depreciation				292,602		292,602		35
36									36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Country Health

# 0007880

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	Dining Room Remodel	1998	\$ 212,044	\$		\$	\$	\$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,891,513	\$ 292,602		\$ 292,602	\$	\$	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		\$ 1,891,513	\$ 292,602		\$ 292,602	\$	\$	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	Ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,017,721	\$ 292,602		\$ 292,602	\$	\$	34

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

Facility Name &amp; ID Number Country Health

# 0007880

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,017,721	\$ 292,602		\$ 292,602	\$	\$	1
2									2
3	Resident Room Remodel-- Flooring, paint	2005	696						3
4	Door Alarm	2005	9,840						4
5	Board Room Remodel -- Paint	2005	741						5
6	Activity Room Remodel -- Paint, Flooring	2005	5,359						6
7	Employee Breakroom Remodel -- Paint	2005	1,182						7
8	Chiller	2005	46,799						8
9	Lobby Remodel -- Paint, Flooring	2005	23,981						9
10	Water valves	2005	24,320						10
11	Roof	2005	6,056						11
12	Nurse Call Station	2005	640						12
13	A/C Units	2005	5,127						13
14	Exterior Rehab	2005	1,172						14
15	Parking Lot Resurface	2005	1,449						15
16	CCTV Monitor and Camera	2005	2,407						16
17	Safety Control --Boiler	2005	1,180						17
18	Landscaping	2005	683						18
19	Dining Room Painting	2005	2,375						19
20	Flooring	2005	1,419						20
21									21
22	Dining Room Painting	2006	4,228						22
23	Landscaping	2006	1,411						23
24	Sewage Grinder	2006	18,519						24
25	Sidewalk	2006	1,997						25
26	Fire Door	2006	1,401						26
27	Resident Room Remodel-- Flooring, paint	2006	6,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,187,553	\$ 292,602		\$ 292,602	\$	\$	34

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

Facility Name &amp; ID Number Country Health

# 0007880

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,187,553	\$ 292,602		\$ 292,602	\$	\$	1
2									2
3	<u>1/2 hp Auto Door Opener</u>	2007	750						3
4	<u>Water Heater</u>	2007	6517						4
5	<u>Roof Repair</u>	2007	851						5
6	<u>Water Main</u>	2007	1462						6
7	<u>Fire System</u>	2007	1662						7
8	<u>Boiler</u>	2007	1044						8
9	<u>Breakers</u>	2007	1393						9
10	<u>Water Softener</u>	2007	1382						10
11									11
12	<u>HVAC Units</u>	2008	3627						12
13	<u>Mixing Valve</u>	2008	8834						13
14	<u>Circulator Pump</u>	2008	2869						14
15									15
16	<u>Water Heater</u>	2009	2860						16
17	<u>Fire Door</u>	2009	4245						17
18									18
19	<u>Water Main</u>	2011	5000						19
20									20
21	<u>Landscapping</u>	2012	18565						21
22	<u>Drywall - Paint &amp; touch-up</u>	2012	3716						22
23	<u>HVAC Compressors</u>	2012	7,500						23
24	<u>Renovation - Contracted Total</u>	2012	6,858,714						24
25	<u>Renovation - Capitalized Interest</u>	2012	673,048						25
26	<u>Renovation - Additional Third Party Costs</u>	2012							26
27	<u>Asbestos</u>	2012	444,405						27
28	<u>Professional Fees</u>	2012	776,516						28
29	<u>Technology</u>	2012	258,985						29
30	<u>Other - Flooring, Drywall Window Treatments</u>	2012	56,856						30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,328,354	\$ 292,602		\$ 292,602	\$	\$	34

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

Facility Name & ID Number Country Health

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 11,328,354	\$ 292,602		\$ 292,602	\$	\$	1
2									2
3	Kitchen Booster Heater	2013	2,781						3
4	Fire Alarm System Module	2013	3,111						4
5	Courtyard Landscaping	2013	2,697						5
6									6
7	Replaced (2) Chiller Motors	2014	2,530						7
8									8
9	Replace Bathroom Flooring	2015	3,362						9
10	Replace Walk-In Cooler	2015	4,096						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,346,931	\$ 292,602		\$ 292,602	\$	\$	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	\$ 1,355,879	\$ 60,129	\$ 60,129	\$		\$	71
72	Current Year Purchases	6,415						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,362,294	\$ 60,129	\$ 60,129	\$		\$	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		2012 Van	2011	\$ 36,633	\$ 5,234	\$ 5,234	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 36,633	\$ 5,234	\$ 5,234	\$		\$	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)	\$ 12,772,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 357,965	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 357,965	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

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: \$ \_\_\_\_\_ 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	\$			\$ 198,718	\$		\$ 198,718	1
2	Licensed Speech and Language Development Therapist		hrs				22,132			22,132	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				255,765	129		255,894	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					195,394		195,394	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						36,208			36,208	13
14	<b>TOTAL</b>			\$			\$ 512,823	\$ 195,523		\$ 708,346	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 Country Health

# 0007880

Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,967,616	\$	1
2	Cash-Patient Deposits	12,554		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	690,696		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,037		6
7	Other Prepaid Expenses	10,682		7
8	Accounts Receivable (owners or related parties)	124,645		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,851,230	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	680,148		13
14	Buildings, at Historical Cost	11,270,391		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,389,617		16
17	Accumulated Depreciation (book methods)	(4,048,221)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 9,291,935	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 12,143,165	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 222,226	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,554		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,118		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	331,816		32
33	Accrued Interest Payable	20,186		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Bed Tax</u>	29,251		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 876,151	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	6,978,975		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,978,975	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,855,126	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,288,039	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 12,143,165	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 4,316,645	1
2	Restatements (describe):		2
3	<b>Audit Adjustment - Real Estate Taxes</b>	(289,675)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 4,026,970	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	261,069	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 261,069	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 4,288,039	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,327,061	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,327,061	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,911,901	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,911,901	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	322,191	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,250	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 342,441	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	18,002	24
25	Interest and Other Investment Income***	11,140	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 29,142	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,610,545	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,096,566	31
32	Health Care	2,905,959	32
33	General Administration	1,428,792	33
<b>B. Capital Expense</b>			
34	Ownership	918,159	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,349,476	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	261,069	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 261,069	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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 Country Health

# 0007880

Report Period Beginning:

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Ending:

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**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	1,832	1,928	\$ 67,190	\$ 34.85	1
2	Assistant Director of Nursing	798	840	25,714	30.61	2
3	Registered Nurses	14,270	15,021	441,770	29.41	3
4	Licensed Practical Nurses	21,857	23,007	556,045	24.17	4
5	CNAs & Orderlies	56,168	59,124	819,171	13.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	942	992	26,517	26.73	8
9	Activity Director					9
10	Activity Assistants	5,101	5,370	68,055	12.67	10
11	Social Service Workers	1,906	2,006	37,064	18.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,745	20,784	233,196	11.22	15
16	Dishwashers					16
17	Maintenance Workers	5,599	5,894	82,630	14.02	17
18	Housekeepers	10,745	11,311	113,088	10.00	18
19	Laundry	5,536	5,827	65,719	11.28	19
20	Administrator	1,976	2,080	84,932	40.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,064	9,541	206,054	21.60	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)	155,539	163,725	\$ 2,827,145 *	\$ 17.27	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	13,200		36
37	Medical Records Consultant	0		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,340		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	3,295		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,835		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

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# 0007880

Report Period Beginning: 01/01/15

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Jason Grill			\$ 84,932	Workers' Compensation Insurance	\$ 62,526	IDPH License Fee	\$			
				Unemployment Compensation Insurance	4,730	Advertising: Employee Recruitment		6,669		
				FICA Taxes	216,277	Health Care Worker Background Check (Indicate # of checks performed _____)		1,962		
				Employee Health Insurance	328,346	Patient Background Checks				
				Employee Meals		PR		7,932		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions		6,210		
				Other Benefits	24,766	License & Fees		3,295		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,932	TOTAL (agree to Schedule V, line 22, col.8)			\$ 636,645	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,090
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description				Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel			
								5,228		
								9		
							Seminar Expense	1,793		
								(2,031)		
							Entertainment Expense	(		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 4,999
C. Professional Services			Amount							
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount		
Heritage Operations Group	Mgt	\$ 164,866								
Sulaski & Webb	Audit	8,600								
ADP	Payroll	1,032								
EIEC	LOC Fee	1,850								
Govig & Assoc	HR Consulting	18,750								
Principal	401 K Mgmt	1,600								
Legal adj to Zero		4,576								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 201,274							

\* 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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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## 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. \$ 48,728  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,772
- (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 Adjustment Line #	Amount
1009	PETTY CASH	1,967,616				1,009	1,009 CASH 1,967,616
1010	CASH IN BANK					1,100	1,100 ACCTS R 755,655
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. (64,959)
1100	ACCOUNTS RECEIVABLE	690,696				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 45,037
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	45,037				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 680,148
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 1,389,617
1409	LAND	680,148				1,460	(1,176,603)
1450	FURNITURE & EQUIPMENT	1,389,617				1,475	1,475 BUILDIN 11,270,391
1460	ACCUM DEPR-FURN & EQU	-1,176,603				1,490	1,490 ACCUM] (2,871,618)
1475	BUILDING & IMPROVEMEN	11,270,391				1,530	1,530 RESIDEN 12,554
1490	ACCUM DEPR-BUILDING	-2,871,618				1,550	1,550 LOAN FE 10,682
1530	RESIDENT FUNDS	12,554				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	10,682				1,850	1,850 INTERCC 124,645
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (222,226)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	124,645				2,100	2,100 ACCRUE (105,548)
2010	ACCOUNTS PAYABLE	-222,226				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-105,548				2,110	2,110 ACCRUE (154,570)
2110	ACCRUED VACATION PAY	-154,570				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 REF	
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 - CAFETE	
2240	UNITED WAY			2,246	2,250 401K W/F	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE G.	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	(20,186)
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(29,251)
2300	ACCRUED INTEREST PAYA	-20,186		2,350	2,350 REAL ES	(331,816)
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-29,251		2,400	2,400 CURRENT PORTION OF LT DEB	
2350	REAL ESTATE TAX PAYAB	-331,816		2,512	2,512 DUE TO 1	(12,554)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(6,978,975)
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 RETAINED	(4,026,970)
2460	INCOME TAXES PAYABLE				net income	(261,069)
2512	DUE TO RESIDENTS	-12,554				
2600	MORTGAGE PAYABLE	-6,978,975				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-4,026,970				
2970	PROFIT/LOSS FOR PERIOD	-261,069				
3007.1	PATIENT DAYS-PRIVATE	16,849				3,007

3007.2	PATIENT DAYS-IPA	10,946						3,007
3007.3	PATIENT DAYS-MEDICARE	2,348						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 &	-4,301,301	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-MEDICARI	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-PRIVA	-13,124	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	-322,191	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,911,901	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	0	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	0		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-12,636		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-20,250		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	187,625	206,054	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	84,932	84,932	17	1	0	0		4,120
4115	VACATION & SICK - G&A	18,429		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	17,793	636,645	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP	5,032		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP	1,941		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	20,873	20,873	21	2	0	0		4,275
4260	TELEPHONE	7,567	7,567	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	6,829	6,829	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	5,228	7,030	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	9		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,793		24	3	19	-2,031 ***		4,289
4290	HELP WANTED ADVERTISING	6,669	93,447	20	3	0	0 -48,728		4,290
4291	PROMOTIONAL ADVERTISING	18,651		20	3	25	-18,651		4,291
4292	PUBLIC RELATIONS	7,932		20	3	25	-7,932		4,292
4300	LICENSES & FEES	52,023		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	6,210		20	3	17	-3,046		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	36,657	201,274	19	3	22	-4,576		4,350
4355	MEDICAL DIRECTOR	13,200	13,200	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 CONSI	0		10	3	0	0	4,364
4363	PHARMACIST FEES	5,340		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,295	3,295	12	3	0	0	4,383
4370	TV RENTAL	8,448		35	3	5	0	4,390
4380	INCOME TAXES		22,968	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,962		20	3	26	0	4,401
4400	PAYROLL TAXES	212,191		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,816		22	3	0	0	4,420
4410	GROUP INSURANCE	328,346		22	3	0	0	4,430
4420	LIABILITY INSURANCE	141,173	141,173	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	62,526		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	164,617		19	3	34	0 **	4,460
4460	BAD DEBTS	22,954		27	3	24	-22,954	4,461
4470	LOST ITEMS-RESIDENTS	14		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	269,499	269,499	33	3	0	0	4,486
4600	LEASED EQUIPMENT	13,502	21,950	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	79,685	82,630	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	2,945		6	1	0	0	4,510
5130	ELECTRIC	163,234	197,849	5	3	0	0	4,600
5131	NATURAL GAS	17,858		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	16,757		5	3	0	0	5,130
5134	TRASH COLLECTION	12,597	66,188	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	3,480	55,966	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	52,486		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	53,591		6	3	0	0	5,140
5210	DIETARY WAGES	220,155	233,196	1	1	0	0	5,160
5220	DIETARY SICK & VAC	13,041		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	225,273	223,501	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,553	20,738	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	7,575		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,610		1	2	0	0	5,260
5295	MEAL CREDIT	-1,772		2	2	0	0	5,270
5310	LAUNDRY WAGES	60,697	65,719	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	5,022		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	5,589	11,112	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,523		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	104,849	113,088	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	8,239		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	26,867	26,579	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	-288		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,936,407	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	403,179		10	1	0	0	6,020
6030	DON WAGES	67,190		10	1	0	0	6,030
6035	ADON	25,714		10	1	0	0	6,035
6040	RN SICK & VACATION	38,591		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	520,548		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	35,497		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	760,453		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	58,718		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 W/	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 RE	0		0	0	0	0	6,295
6270	REHAB WAGES	26,699		10	1	0	0	6,390
6275	REHAB SICK & VAC	-182		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	118,847	127,782	10	2	0	0	7,281
6295	NURSING SUPPLIES	4,016		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	4,919		10	2	0	0	7,391
6490	NURSING OTHER	1,970	7,310	10	3	0	0	7,393
7280	DRUG PURCHASES	194,203	195,523	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	1,191		39	2			7,540
7380	LABORATORY SERVICES	36,208	512,823	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	63,373	68,055	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,682		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	4,500	4,500	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	255,765		39	3	0	0 ***	7,890
7660	PT SUPPLIES	129		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	34,436	37,064	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	2,628		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	198,718		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	22,132		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	265,314	268,745	32	3	14	-11,140	
8130	DEPRECIATION	357,965	357,965	30	3	9	0	
8150	LOAN FEE AMORTIZATION	3,431		32	3	0	0	0
9510	INTEREST INCOME	-11,140		32	0	10	0	
9520	MISC NON-OPERATING INC	-18,002		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		6,320,334	6,349,476					
			29,142					

GRAND TOTALS -261,069 -70,330  
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP	16,849	16,849
IPA	10,946	10,946
medicare	2,348	2,348
		30,143



UND

RIA

BT

BT

3,007 PATIENT	10,946
3,007 PATIENT	2,348
	0

3,010 BASIC CI (4,301,301)

3,020 BASIC CI 0

3,030 BASIC CI 0

0

0

0

0

3,080 NURSING (13,124)

3,081 NURSING 0

3,082 NURSING 0

3,083 NURSING 0

3,100 DRUGS-M (322,191)

0

3,110 PHYSICIAN (1,911,901)

0

3,112 PHYSICIAN 0

3,113 PHYSICIAN 0

3,140 LABORATORY INCOME

0

3,152 ST/OT TR 0

3,153 ST/OT TR 0

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER 0

3,411 MEDICAL 0

3,420 MEDICARE DISCOUNTS

3,520 RENT INC	0
3,530 BEAUTY	0
	0
3,570	
3,590 EQUIPMI	(12,636)
3,595 RESIDEN	(20,250)
3,600 MISC INC	0
4,110 G&A WA	187,625
4,111 ADMINIS	84,932
4,115 G&A PTC	18,429
4,120 EMPLOY	15,544
4,130 EMPLOY	5,032
4,135 EMPLOY	1,941
4,250 OFFICE S	10,680
4,255 POSTAGI	1,305
4,260 TELEPHC	7,567
4,275 TRAININ	6,829
4,280 GENERA	5,228
4,281 MEAL EX	9
4,285 EDUCAT	1,592
4,289 MEETING	201
4,290 HELP WA	6,669
4,291 PROMOT	18,651
4,292 PUBLIC I	7,932
4,300 LICENSE	52,023
4,310 DUES & :	6,210
4,320 CONTRIE	0
4,350 PROFESS	36,657
4,355 MEDICAL	13,200
	5,340

4,364 SOCIAL S	3,295
4,370 TV RENT	8,448
4,383 BACKGR	1,962
4,390 OTHER T	0
4,400 PAYROL	212,191
4,401 PAYROL	8,816
4,410 GROUP I	328,346
4,420 LIABILIT	141,173
4,430 WORKM	60,347
4,435 W/C-FIRS	240
4,436 DRUG TE	1,939
4,450 MANAGI	164,617
4,460 BAD DEF	22,954
4,461 BAD DEBTS	
4,470 LOST ITE	14
4,475 UNIFORM	2,249
4,486 SERVICE	28,982
4,490 MISC EX	16
4,496 MISC. M.	8,888
4,510 REAL ES	269,499
4,600 LEASED	13,502
5,110 MAINTEI	79,685
5,120 MAINTEI	2,945
5,130 ELECTRI	163,234
5,131 NATURA	17,858
5,133 WATER &	16,757
5,134 TRASH C	12,597
5,140 PROP/PL	3,480
5,160 GENERA	52,486
5,165 MAINTEI	24,609
5,210 DIETARY	220,155
5,220 DIETARY	13,041
5,248 FOOD PU	225,257

5,250 SUPPLIE	3,553
5,260 REPLACI	7,575
5,270 KITCHEN	9,610
5,295 MEAL IN	(1,772)
5,310 LAUNDR	60,697
5,340 LAUNDR	5,022
5,370 REPLACI	5,589
	274
5,390 SUPPLIE	5,249
5,410 HOUSEK	104,849
5,440 HOUSEK	8,239
5,480 SUPPLIE	26,867
5,490 SUPPLIE	(288)
6,020 RN WAG	403,179
6,030 DON WA	67,190
6,035 ADON W	25,714
6,040 RN PTO &	38,591
6,120 LPN WAG	520,548
6,140 LPN PTO	35,497
6,220 AIDES W	760,453
6,240 AIDES PT	58,718
	0
	0
	0
6,270 REHAB V	26,699
6,275 REHAB F	(182)
6,290 NURSINC	118,847
6,295 NURSINC	4,016
6,390 REPLACI	4,919
6,490 OTHER	1,970

7,280 DRUG PU	194,203
7,281 DRUG PU	1,191
7,380 LABORA	12,012
7,390 X-RAY S	24,196
7,510 ACTIVIT	63,373
7,540 ACTIVIT	4,682
7,590 ACTIVIT	4,500
7,620 PHYSICA	255,765
7,660 P.T. SUPE	129
7,710 SOCIAL S	34,436
7,720 SOCIAL S	2,628
7,730 SOCIAL SERVICE-EXPENSES	
7,740 OCCUPA	198,718
7,770 SPEECH '	22,132
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	265,314
	0
8,130 DEPRECI	357,965
	3,431
9,510 INTERES	(11,140)
9,520 MISC NO	(18,002)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(261,069)</u>

Expenses Fixed Assets

