

Facility Name & ID Number Heritage Health Bloomington

0048157 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	111	Skilled (SNF)	111	40,515	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	111	TOTALS	111	40,515	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	9,287	12,813	3,356	25,456	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,287	12,813	3,356	25,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.83%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started July 2006

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 3,356

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Heritage Health Bloomington

0048157

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
	A. General Services										
1	Dietary	263,681	17,328		281,009		281,009	5,922	286,931		1
2	Food Purchase		189,866		189,866		189,866	34	189,900		2
3	Housekeeping	106,390	33,465		139,855		139,855	43	139,898		3
4	Laundry	67,596	17,143		84,739		84,739		84,739		4
5	Heat and Other Utilities			105,814	105,814		105,814	1,537	107,351		5
6	Maintenance	100,466	56,762	84,198	241,426		241,426	18,114	259,540		6
7	Other (specify):*										7
8	TOTAL General Services	538,133	314,564	190,012	1,042,709		1,042,709	25,650	1,068,359		8
	B. Health Care and Programs										
9	Medical Director			15,828	15,828		15,828		15,828		9
10	Nursing and Medical Records	2,076,183	217,257	46,418	2,339,858		2,339,858	(20,067)	2,319,791		10
10a	Therapy		726,538	733,061	1,459,599	(780,646)	678,953		678,953		10a
11	Activities	59,617	2,596		62,213		62,213		62,213		11
12	Social Services	66,385		426	66,811		66,811		66,811		12
13	CNA Training			384	384		384	1,054	1,438		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,202,185	946,391	796,117	3,944,693	(780,646)	3,164,047	(19,013)	3,145,034		16
	C. General Administration										
17	Administrative	88,000			88,000		88,000		88,000		17
18	Directors Fees										18
19	Professional Services			307,504	307,504		307,504	(285,302)	22,202		19
20	Dues, Fees, Subscriptions & Promotions			120,999	120,999	(60,773)	60,226	(29,230)	30,996		20
21	Clerical & General Office Expenses	211,678	24,200	32,282	268,160		268,160	354,359	622,519		21
22	Employee Benefits & Payroll Taxes			695,987	695,987		695,987	52,917	748,904		22
23	Inservice Training & Education			12,453	12,453		12,453	1,005	13,458		23
24	Travel and Seminar			6,986	6,986		6,986	(1,987)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,254	79,254		79,254		79,254		26
27	Other (specify):*			9,600	9,600		9,600	(9,600)			27
28	TOTAL General Administration	299,678	24,200	1,265,065	1,588,943	(60,773)	1,528,170	82,162	1,610,332		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,039,996	1,285,155	2,251,194	6,576,345	(841,419)	5,734,926	88,799	5,823,725		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation						587,370	587,370			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			29,941	29,941		29,941	138,578	168,519		32
33	Real Estate Taxes							86,147	86,147		33
34	Rent-Facility & Grounds			486,182	486,182		486,182	(488,490)	(2,308)		34
35	Rent-Equipment & Vehicles			21,334	21,334		21,334	8,841	30,175		35
36	Other (specify):*										36
37	TOTAL Ownership			537,457	537,457		537,457	332,446	869,903		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers						780,646	780,646	(184,465)	596,181	39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee						60,773	60,773	60,773		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers						841,419	841,419	(184,465)	656,954	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,039,996	1,285,155	2,788,651	7,113,802		7,113,802	236,780	7,350,582		45

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

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning: 01/01/15

Ending: 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	(8,652)			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	(1,148)			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	(9,371)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,532)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,600)			24
25	Fund Raising, Advertising and Promotional	(37,434)			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)	\$ (70,737)		\$	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)	307,517		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 307,517		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 236,780		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Health Bloomington

ID# 0048157

Report Period Beginning: 01/01/15

Ending: 12/31/15

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		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,532)	19	22
23				23
24		(9,600)	27	24
25		(37,434)	20	25
26				26
27		(8,652)	34	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		(60,218)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Bloomington# 0048157

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,922	0	0	0	0	0	0	0	0	5,922	1
2	Food Purchase	0	0	34	0	0	0	0	0	0	0	0	34	2
3	Housekeeping	0	0	43	0	0	0	0	0	0	0	0	43	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,537	0	0	0	0	0	0	0	0	1,537	5
6	Maintenance	0	0	18,114	0	0	0	0	0	0	0	0	18,114	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	25,650	0	0	0	0	0	0	0	0	25,650	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	(20,765)	698	0	0	0	0	0	0	0	0	(20,067)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,054	0	0	0	0	0	0	0	0	1,054	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	(20,765)	1,752	0	0	0	0	0	0	0	0	(19,013)	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	(4,532)	(302,033)	21,263	0	0	0	0	0	0	0	0	(285,302)	19
20	Fees, Subscriptions & Promotions	(37,434)	0	8,204	0	0	0	0	0	0	0	0	(29,230)	20
21	Clerical & General Office Expenses	0	0	354,359	0	0	0	0	0	0	0	0	354,359	21
22	Employee Benefits & Payroll Taxes	0	0	52,917	0	0	0	0	0	0	0	0	52,917	22
23	Inservice Training & Education	0	(110)	1,115	0	0	0	0	0	0	0	0	1,005	23
24	Travel and Seminar	(9,371)	0	7,384	0	0	0	0	0	0	0	0	(1,987)	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):*	(9,600)	0	0	0	0	0	0	0	0	0	0	(9,600)	27
28	TOTAL General Administration	(60,937)	(302,143)	445,242	0	0	0	0	0	0	0	0	82,162	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(60,937)	(322,908)	472,644	0	0	0	0	0	0	0	0	88,799	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Bloomington

0048157

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)	
	D. Ownership													
30	Depreciation	0	565,604	0	21,766	0	0	0	0	0	0	0	587,370	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,148)	139,794	0	(68)	0	0	0	0	0	0	0	138,578	32
33	Real Estate Taxes	0	86,147	0	0	0	0	0	0	0	0	0	86,147	33
34	Rent-Facility & Grounds	(8,652)	(486,182)	0	6,344	0	0	0	0	0	0	0	(488,490)	34
35	Rent-Equipment & Vehicles	0	0	0	8,841	0	0	0	0	0	0	0	8,841	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,800)	305,363	0	36,883	0	332,446	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	(184,465)	0	0	0	0	0	0	0	0	0	(184,465)	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	(184,465)	0	0	0	0	0	0	0	0	0	(184,465)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(70,737)	(202,010)	472,644	36,883	0	236,780	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attached Following This Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt. Services</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 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	<u>10 Adjustment for Related Organization</u>	\$	<u>GreenTree Pharmacy</u>	<u>0.00%</u>	\$ <u>(20,765)</u>	\$ <u>(20,765)</u>	1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(110)</u>	<u>(110)</u>	2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(184,465)</u>	<u>(184,465)</u>	3
4	V	<u>19 Adjustment for Related Organization</u>	<u>302,033</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(302,033)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>486,182</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(486,182)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>86,147</u>	<u>86,147</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>128,961</u>	<u>128,961</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>565,604</u>	<u>565,604</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>10,833</u>	<u>10,833</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 788,215			\$ 586,205	\$ * (202,010)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$ 5,922	15
16	V	2 Food Purchase					34	16
17	V	3 Housekeeping					43	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,537	19
20	V	6 Maintenance					18,114	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					698	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,054	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					0	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					21,263	31
32	V	20 Fees, Subscription, Promotions					8,204	32
33	V	21 Clerical & General Office Expenses					354,359	33
34	V	22 Employee Benefits & Payroll Taxes					52,917	34
35	V	23 Inservice Training & Education					1,115	35
36	V	24 Travel and Seminar					7,384	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					0	38
39	Total		\$			\$	0	\$ * 472,644 39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$	\$	0 15
16	V	30 Depreciation						21,766 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						(68) 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						6,344 20
21	V	35 Rent-Equipment & Vehicles						8,841 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	0	\$ * 36,883 39

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 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	Heritage Enterprises Inc.	Sole Member		100.00					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Health Bloomington

0048157

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 Heritage Operations Group
 Street Address Box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,835	27	\$ 151,240	\$ 150,308	111	\$ 5,922	1
2	2	Food Purchase	Beds	2,835	27	878	0	111	34	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	111	43	3
4	4	Laundry	Beds	2,835	27	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	111	1,537	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	111	18,114	6
7	7	Other	Beds	2,835	27	0	0	111	0	7
8	9	Medical Director	Beds	2,835	27	0	0	111	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	111	698	9
10	11	Activities	Beds	2,835	27	0	0	111	0	10
11	12	Social Service	Beds	2,835	27	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	111	1,054	12
13	14	Program Transportation	Beds	2,835	27	0	0	111	0	13
14	15	Other	Beds	2,835	27	0	0	111	0	14
15	17	Administrative	Beds	2,835	27	0	0	111	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	111	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	111	21,263	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	111	8,204	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	111	354,359	19
20	22	Employee Benefits & Payroll Tax	Beds	2,835	27	1,351,528	0	111	52,917	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	111	1,115	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	111	7,384	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0		0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0		0	24
25	TOTALS					\$ 12,462,987	\$ 8,837,683		\$ 472,644	25

Facility Name & ID Number Heritage Health Bloomington

0048157

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 See Pg 8
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,835	26	\$	\$	111	\$	1
2	30	Depreciation	Beds	2,835	26	555,915	111	21,766		2
3	31	Amortization of Pre-Op & Org	Beds	2,835	26		111			3
4	32	Interest	Beds	2,835	26	(1,746)	111	(68)		4
5	33	Real Estate Taxes	Beds	2,835	26		111			5
6	34	Rent-Facility & Grounds	Beds	2,835	26	162,022	111	6,344		6
7	35	Rent-Equipment & Vehicles	Beds	2,835	26	225,798	111	8,841		7
8	36	Other	Beds	2,835	26		111			8
9	38	Medically Nec Transportation	Beds	2,835	26		111			9
10	39	Ancillary Service Centers	Beds	2,835	26		111			10
11	40	Barber and Beauty Shops	Beds	2,835	26		111			11
12	41	Coffee and Gift Shops	Beds	2,835	26		111			12
13	42	Other	Beds	2,835	26		111			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					\$ 941,989	\$		\$ 36,883	25

Facility Name & ID Number

Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Bank of America		x	Mortgage			\$	\$			\$ 128,961					
2	Bank of America		x	Loan Fee Amortization							10,833					
3																
4																
5																
Working Capital																
6	Bank of America		x	Working Capital							29,941					
7																
8																
9	TOTAL Facility Related						\$	\$			\$ 169,735					
B. Non-Facility Related*																
10	Interest Income										(1,148)					
11																
12	Allocated Corporate										(68)					
13																
14	TOTAL Non-Facility Related						\$	\$			\$ (1,216)					
15	TOTALS (line 9+line14)						\$	\$			\$ 168,519					

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.)

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

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>2104227012</u>	_____	\$ 85,273.24	\$ 85,273.24
2. <u>2104227010</u>	_____	\$ 436.88	\$ 436.88
3. <u>2104227009</u>	_____	\$ 436.88	\$ 436.88
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>86,147.00</u>	\$ <u>86,147.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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: 38,544 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>255,078</u>	1
2					2
3	TOTALS			\$ <u>255,078</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	111			\$ 560,548	\$		\$	\$
5				221,147				
6								
7								
8								
Improvement Type**								
9	1978 Improvements	1978		14,607				
10	1979 Improvements	1979		95,460				
11	1980 Improvements	1980		75,591				
12	1981 Improvements	1981		11,544				
13	1982 Improvements	1982		9,256				
14	1983 Improvements	1983		13,130				
15	1984 Improvements	1984		7,215				
16	1985 Improvements	1985		45,885				
17	1986 Improvements	1986		13,469				
18	1988 Improvements	1988		83,109				
19	1989 Improvements	1989		2,439				
20	1990 Improvements	1990		30,676				
21	1991 Improvements	1991		4,207				
22	1992 Improvements	1992		1,208				
23	1993 Improvements	1993		97,303				
24	1994 Improvements	1994		29,638				
25	1995 Improvements	1995		121,304				
26	BOILER	1996		17,850				
27	EXHAUST HOOD	1996		1,075				
28	CODE ALERT	1996		1,852				
29	PHONE SYSTEM	1996		2,339				
30	INTERIOR REMODEL	1996		103,103				
31								
32								
33	C/O Allocation				21,766		21,766	
34	Book Depreciation				403,063		403,063	
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	Interior Rehab--paint, wallpaper, remodel facility	1997	\$ 211,945	\$		\$	\$	\$	37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63	Adj to Capital Report	2000	(2,383)						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,187,775	\$ 424,829		\$ 424,829	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,187,775	\$ 424,829		\$ 424,829	\$	\$	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9	Smoke Detectors and Installation	2002	14,551						9
10	Mixing valve	2002	1,862						10
11	Main Corridor Rehab (Wallcovering)	2002	3,885						11
12	Floor Tile	2002	1,280						12
13	Kitchen	2002	957						13
14	Roof Repair	2002	5,283						14
15									15
16	Smoke Detectors and Installation	2003	5,970						16
17	Roof Replacement	2003	111,250						17
18	Sprinklers	2003	31,119						18
19	Parking Lot	2003	3,862						19
20	Ceramic Tile	2003	1,315						20
21	Compressor	2003	3,898						21
22	Wallpaper	2003	857						22
23	Maglock Keypad	2003	2,762						23
24	ANSUL Fire Surpression	2003	1,450						24
25	Fire Escape Remodel	2003	2,003						25
26	Adj to Capital Report	2003	(14,958)						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,379,180	\$ 424,829		\$ 424,829	\$	\$	34

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

Facility Name & ID Number Heritage Health Bloomington

0048157

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	Totals from Page 12B, Carried Forward		\$ 3,379,180	\$ 424,829		\$ 424,829	\$	\$	1
2	Sewage Pump	2004	3,823						2
3	Nurses Station A/C	2004	1,478						3
4	Fire Alarm	2004	2,825						4
5	Sealcoat Parking Lot	2004	1,646						5
6	Storm Windows	2004	645						6
7	Window A/C (8)	2004	6,030						7
8	Ceiling Repairs	2004	4,011						8
9									9
10	Delayed Egress Latches	2005	12,431						10
11	Mixing valve	2005	1,360						11
12	Paint ceiling	2005	596						12
13	A/C	2005	2,153						13
14	Sidewalk	2005	2,100						14
15									15
16	Plumbing	2006	6,791						16
17	A/C -- Thru wall units	2006	6,900						17
18	Exterior Painting	2006	11,650						18
19	Compressor	2006	5,015						19
20	Condensing Unit	2006	4,902						20
21	Insinkerator	2006	2,350						21
22	Water Softener	2006	27,469						22
23	Basement De-watering	2006	3,750						23
24	Paint Kitchen	2006	1,820						24
25	Repair building	2006	1,199						25
26	Landscaping	2006	1,335						26
27	Pump Motor	2006	1,072						27
28	Mixing valve	2006	2,884						28
29	Adj to Capital Report	2006	(722)						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,494,693	\$ 424,829		\$ 424,829	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,494,693	\$ 424,829		\$ 424,829	\$	\$	1
2	Resident Rooms Remodel -- Paint and flooring	2007	13,957						2
3	Sprinkler	2007	1,152						3
4	Compressor	2007	4,006						4
5	Condensor	2007	2,250						5
6	Water Heater	2007	7,359						6
7	Therapy Room Remodel-- Paint & Flooring	2007	2,527						7
8	Window treatments	2007	583						8
9	Cooler	2007	642						9
10	Boiler	2007	4,803						10
11	Adj to Capital Report	2007	(8,178)						11
12	Heat/Cool Units	2008	5,420						12
13	Replace Fire Escape	2008	13,577						13
14	Schematic Design (Architect Fees) Facility Renovation	2008	26,038						14
15	Water Heater --Backflow	2008	4,926						15
16	Fire Alarm	2008	63,563						16
17	Water Heater	2008	6,057						17
18	Adj to Capital Report	2008	(19,981)						18
19	HVAC Unit	2009	7,035						19
20	Compressor	2009	4,658						20
21	HVAC Renovation: Boilers, ducts, hvac units & labor	2009	360,549						21
22	Windows	2009	148,790						22
23									23
24	HVAC Renovation: Boilers, ducts, hvac units & labor	2010	15,355						24
25	Architect, engineering fees	2010	87,978						25
26	trane compressor	2010	6,255						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,254,014	\$ 424,829		\$ 424,829	\$	\$	34

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

Facility Name & ID Number Heritage Health Bloomington

0048157

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	Totals from Page 12D, Carried Forward		\$ 4,254,014	\$ 424,829		\$ 424,829	\$	\$	1
2									2
3	<u>Signage</u>	2011	9,969						3
4									4
5	<u>PT Addition 2010 & 2011 - Contracted Total</u>	2011	1,604,828						5
6	<u>PT Addition 2010 & 2011 - Capitalized Interest</u>	2011	7,278						6
7	<u>Renovation 2010 & 2011 - Contracted Total</u>	2011	2,381,723						7
8	<u>Renovation 2010 & 2011 - Capitalized Interest</u>	2011	15,565						8
9	<u>Renovation 2010 & 2011 - Third Party Costs:</u>								9
10	<u>Architect</u>	2011	44,486						10
11	<u>Asbestos</u>	2011	99,441						11
12	<u>Construction Certificate Consultant</u>	2011	6,150						12
13	<u>Elevator</u>	2011	4,000						13
14	<u>Engineer</u>	2011	9,238						14
15	<u>Landscaping</u>	2011	17,814						15
16	<u>Legal/Plan Review</u>	2011	12,720						16
17	<u>Plumbing</u>	2011	10,340						17
18	<u>Signage, Electric,HVAC & Supplies</u>	2011	4,352						18
19	<u>Sitework</u>	2011	3,795						19
20	<u>Technology</u>	2011	321,596						20
21	<u>Window Coverings</u>	2011	5,295						21
22									22
23	<u>PT Addition (Additional Costs) - Signage</u>	2012	2,213						23
24	<u>Renovation (Additional Costs)</u>								24
25	<u>Architect</u>	2012	749						25
26	<u>Asbestos</u>	2012	16,910						26
27	<u>Landscaping</u>	2012	70,935						27
28	<u>Plumbing</u>	2012	1,325						28
29	<u>Signage, Electric,HVAC & Supplies</u>	2012	6,275						29
30	<u>Technology</u>	2012	60,097						30
31	<u>Window Coverings</u>	2012	27,483						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,998,591	\$ 424,829		\$ 424,829	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,998,591	\$ 424,829		\$ 424,829	\$	\$	1
2									2
3	Nurse Master Console	2012	5,031						3
4									4
5	Replacement- sprinkler heads, floor tile & countertop-1 Rm.	2013	10,395						5
6									6
7	Elevator Power Unit Replacement	2013	11,425						7
8	Point of Care Kiosk Cabling	2013	7,985						8
9	Air conditioning units - new	2013	3,646						9
10									10
11	Final Charge - Elevator Power Replacement	2014	8,275						11
12	Install 9 PTAC Units	2014	3,834						12
13	Elevator Upgrades-Code Requirements	2014	10,153						13
14	Install Split Replacement Systems - Rooms 129 and 130	2014	18,566						14
15	Parking Lot Upgrades	2014	10,025						15
16	Replace Sewage Ejection Pump	2014	6,146						16
17									17
18	Install (6) PTAC units	2015	2,730						18
19	Replaced east dining room compressor	2015	3,685						19
20	Replace sewage ejection pump	2015	4,406						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)		\$ 9,104,893	\$ 424,829		\$ 424,829	\$	\$	34

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

Facility Name & ID Number Heritage Health Bloomington

0048157

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	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		\$ 9,104,893	\$ 424,829		\$ 424,829	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 9,104,893	\$ 424,829		\$ 424,829	\$	\$

**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	\$ 2,247,229	\$ 162,541	\$ 162,541	\$		\$	71
72	Current Year Purchases	17,172						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,264,401	\$ 162,541	\$ 162,541	\$		\$	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)	\$ 11,624,372	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 587,370	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 587,370	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: \$ 21,334 Description: Televisions and copiers

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	255,646	\$		\$	255,646	1
2	Licensed Speech and Language Development Therapist		hrs				98,737				98,737	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				324,378		192		324,570	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						726,346		726,346	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						54,300				54,300	13
14	TOTAL			\$		\$	733,061	\$	726,538	\$	1,459,599	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Health Bloomington

0048157

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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	11,487		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	975,133		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,798		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,216,466)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,198,648)	\$	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)	\$ (1,198,648)	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 407,381	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,394		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,943		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>	22,071		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 703,289	\$	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)	\$ 703,289	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,901,937)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,198,648)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,873,862)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,873,862)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(28,075)	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)	\$ (28,075)	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)	\$ (1,901,937)	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	\$ 6,271,600	1
2	Discounts and Allowances for all Levels	(3,230,281)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,041,319	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,620,472	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,620,472	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		12
13	Barber and Beauty Care	1,664	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,652	16
17	Sale of Drugs	1,412,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,422,788	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,148	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,148	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)	\$ 7,085,727	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,042,709	31
32	Health Care	3,944,693	32
33	General Administration	1,588,943	33
B. Capital Expense			
34	Ownership	537,457	34
C. Ancillary Expense			
35	Special Cost Centers		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)*	\$ 7,113,802	40
41	Income before Income Taxes (line 30 minus line 40)**	(28,075)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (28,075)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,611	1,696	\$ 62,943	\$ 37.11	1
2	Assistant Director of Nursing	1,808	1,903	82,001	43.09	2
3	Registered Nurses	15,855	16,689	512,199	30.69	3
4	Licensed Practical Nurses	17,621	18,548	482,871	26.03	4
5	CNAs & Orderlies	57,763	60,803	892,227	14.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,567	1,649	43,942	26.65	8
9	Activity Director					9
10	Activity Assistants	4,556	4,796	59,617	12.43	10
11	Social Service Workers	3,495	3,679	66,385	18.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,004	21,057	263,681	12.52	15
16	Dishwashers					16
17	Maintenance Workers	5,506	5,796	100,466	17.33	17
18	Housekeepers	8,012	8,434	106,390	12.61	18
19	Laundry	5,146	5,417	67,596	12.48	19
20	Administrator	1,976	2,080	88,000	42.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,593	7,993	211,678	26.48	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)	152,513	160,540	\$ 3,039,996 *	\$ 18.94	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	15,828		36
37	Medical Records Consultant	38,180		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,609		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	426		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 59,043		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

Facility Name & ID Number Heritage Health Bloomington

Report Period Beginning: 01/01/15

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	
Susan Holifield			\$ 88,000	Workers' Compensation Insurance	\$ 76,583	IDPH License Fee	\$	
				Unemployment Compensation Insurance	37,531	Advertising: Employee Recruitment	9,128	
				FICA Taxes	232,560	Health Care Worker Background Check (Indicate # of checks performed _____)	5,090	
				Employee Health Insurance	269,107	Patient Background Checks		
				Employee Meals		PR	17,209	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	11,148	
				Other Benefits	80,206	License & Fees	2,054	
				Central Office Allocation	52,917	Central Office Allocation	8,204	
						Less: Public Relations Expense	(17,209)	
						Non-allowable advertising	(4,628)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 748,904	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,996	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								4,923
								23
							Seminar Expense	2,040
								(1,987)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
C. Professional Services								
Vendor/Payee	Type	Amount						
Heritage Operations Group	Mgt & Other	\$ 302,599						
ADP	Payroll Tax Processing	1,140						
Legal adj to Zero		3,765						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 307,504					

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Heritage Health Bloomington# 0048157

Report Period Beginning:

01/01/15

Ending:

12/31/15**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. \$ 60,773
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. \$ 6,023
- (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	400				1,009	1,009 PETTY C 400
1010	CASH IN BANK					1,100	1,100 ACCTS R 1,083,514
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. (108,381)
1100	ACCOUNTS RECEIVABLE	975,133				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 30,798
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	30,798				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 0
1409	LAND	0				1,460	0
1450	FURNITURE & EQUIPMENT	0				1,475	1,475 CODE AI 0
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM] 0
1475	BUILDING & IMPROVEMEN	0				1,530	1,530 RESIDEN 11,487
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	11,487				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (2,216,466)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (407,381)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-2,216,466				2,100	2,100 ACCRUE (99,782)
2010	ACCOUNTS PAYABLE	-407,381				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-99,782				2,110	2,110 ACCRUE (156,612)
2110	ACCRUED VACATION PAY	-156,612				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(5,943)	
2125	FICA TAX PAYABLE	-5,943	-5,943	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 GARNISHMENT		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(22,071)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-22,071		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO 1	(11,500)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	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 RETAINED	1,873,862	
2460	INCOME TAXES PAYABLE				net income	28,075	
2512	DUE TO RESIDENTS	-11,500					
2600	MORTGAGE PAYABLE	0					
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>	
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	1,873,862					
2970	PROFIT/LOSS FOR PERIOD	28,075					
3007.1	PATIENT DAYS-PRIVATE	12,813					3,007

3007.2	PATIENT DAYS-IPA	9,287						3,007
3007.3	PATIENT DAYS-MEDICARE	3,356						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 &	-6,234,131	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	-28,695	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	-1,412,472	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,620,472	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	3,230,281	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	-8,652		6	0	6	-8,652		3,530
3530	13 BEAUTY SHOP	-1,664		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	-8,774		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	192,599	211,678	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	88,000	88,000	17	1	0	0		4,120
4115	VACATION & SICK - G&A	19,079		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	33,218	695,987	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	28,634		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	18,354		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	24,200	24,200	21	2	0	0		4,275
4260	TELEPHONE	32,282	32,282	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	12,453	12,453	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	4,923	6,986	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	23		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	2,040		24	3	19	-9,371 ***		4,289
4290	HELP WANTED ADVERTISING	9,128	120,999	20	3	0	0 -60,773		4,290
4291	PROMOTIONAL ADVERTISING	15,597		20	3	25	-15,597		4,291
4292	PUBLIC RELATIONS	17,209		20	3	25	-17,209		4,292
4300	LICENSES & FEES	62,827		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	11,148		20	3	17	-4,628		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	5,471	307,504	19	3	22	-4,532		4,350
4355	MEDICAL DIRECTOR	15,828	15,828	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	38,180		10	3	0	0	4,364
4363	PHARMACIST FEES	4,609		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	426	426	12	3	0	0	4,383
4370	TV RENTAL	11,145		35	3	5	0	4,390
4380	INCOME TAXES		9,600	27	3	26	0	4,400
4383	BACKGROUND CHECKS	5,090		20	3	26	0	4,401
4400	PAYROLL TAXES	260,957		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	9,134		22	3	0	0	4,420
4410	GROUP INSURANCE	269,107		22	3	0	0	4,430
4420	LIABILITY INSURANCE	79,254	79,254	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	76,583		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	302,033		19	3	34	0 **	4,460
4460	BAD DEBTS	9,600		27	3	24	-9,600	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	10,189	21,334	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	92,788	100,466	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	7,678		6	1	0	0	4,510
5130	ELECTRIC	51,008	105,814	5	3	0	0	4,600
5131	NATURAL GAS	28,677		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	26,129		5	3	0	0	5,130
5134	TRASH COLLECTION	11,596	84,198	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	7,261	56,762	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	49,501		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	72,602		6	3	0	0	5,140
5210	DIETARY WAGES	245,018	263,681	1	1	0	0	5,160
5220	DIETARY SICK & VAC	18,663		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	195,889	189,866	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,667	17,328	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	4,485		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,176		1	2	0	0	5,260
5295	MEAL CREDIT	-6,023		2	2	0	0	5,270
5310	LAUNDRY WAGES	62,976	67,596	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,620		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	12,219	17,143	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	4,924		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	95,440	106,390	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	10,950		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	33,450	33,465	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	15		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,076,183	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	464,415		10	1	0	0	6,020
6030	DON WAGES	62,943		10	1	0	0	6,030
6035	ADON	82,001		10	1	0	0	6,035
6040	RN SICK & VACATION	47,784		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	452,314		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	30,557		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	848,500		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	43,727		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	384	384	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	39,873		10	1	0	0	6,390
6275	REHAB SICK & VAC	4,069		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	185,216	217,257	10	2	0	0	7,281
6295	NURSING SUPPLIES	27,436		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	4,605		10	2	0	0	7,391
6490	NURSING OTHER	3,629	46,418	10	3	0	0	7,393
7280	DRUG PURCHASES	420,878	726,538	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	305,468		39	2			7,540
7380	LABORATORY SERVICES	54,300	733,061	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	55,824	59,617	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	3,793		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	2,596	2,596	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	324,378		39	3	0	0 ***	7,890
7660	PT SUPPLIES	192		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	62,265	66,385	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	4,120		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	255,646		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	98,737		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	486,182	486,182	34	3	0	0	

8120	INTEREST EXPENSE	29,941	29,941	32	3	14	-1,148	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-1,148		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		7,112,654	7,113,802					
			1,148					

GRAND TOTALS

28,075
(NET INCOME) -70,737

0
FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	12,813	12,813
IPA	9,287	9,287
medicare	3,356	3,356
		25,456

UND

RIA

BT

BT

3,007 PATIENT DAYS-PRIV 12,813

HFS 3745 (N-4-99)

IL478-2471

3,007 PATIENT DAYS-IPA	9,287
3,007 PATIENT DAYS-MEI	3,356
	0
3,010 BASIC CHARGE-PRF	(6,234,131)
3,020 BASIC CHARGE-IPA	0
3,030 BASIC CHARGE-MEI	0
	0
	0
	0
	0
3,080 NURSING SUPPL-PRF	(28,695)
3,081 NURSING SUPPLIES-IPA	
3,082 NURSING SUPPLIES-M/C A	
3,083 NURSING SUPPLIES-M/C B	
3,100 DRUGS-MEDICARE	(1,412,472)
3,110 PHYSICAL THERAPY	(2,620,472)
	0
3,112 PHYSICAL THERAPY	0
3,113 PHYSICAL THERAPY	0
3,140 LABORATORY INCOME	
	0
3,152 ST/OT THERAPY-M/C	0
3,153 ST/OT THERAPY-M/C	0
3,185 REHAB/ISOLATION/OTHER CHG	
3,410 IPA/OTHER DISCOU	0
3,411 MEDICARE PT B-DIS	0
3,420 MEDICARE DISCOU	3,208,193

3,520 RENT INCOME	(8,652)
3,530 BEAUTY SHOP	(1,664)
	0
3,570 VENDING INCOME & EXPENSE	
3,590 EQUIPMENT RENTA	(8,774)
3,595 RESIDENT TRANSPORTATION	
3,600 MISC INCOME	0
4,110 G&A WAGES	192,599
4,111 ADMINISTRATOR W	88,000
4,115 G&A PTO & RESERV	19,079
4,120 EMPLOYEE BENEFIT	32,920
4,130 EMPLOYEE SCHOLA	28,634
4,135 EMPLOYEE SCHOLA	18,354
4,250 OFFICE SUPPLIES	11,579
4,255 POSTAGE	3,855
4,260 TELEPHONE	32,282
4,275 TRAINING & EMPLC	12,453
	0
4,280 GENERAL TRAVEL	4,923
4,281 MEAL EXPENSE FOF	23
4,285 EDUCATION/SEMIN.	1,966
4,289 MEETINGS EXPENSI	74
4,290 HELP WANTED ADV	9,128
4,291 PROMOTIONAL ADV	15,597
4,292 PUBLIC RELATIONS	17,209
4,300 LICENSE & FEES	62,827
4,310 DUES & SUBSCRIPTI	11,148
4,320 CONTRIBUTIONS	0
4,350 PROFESSIONAL FEE	5,471
4,355 MEDICAL DIRECTOI	15,828
	38,180
	4,609

4,364 SOCIAL SERV/ACT C	426
4,370 TV RENTAL	11,145
4,383 BACKGROUND CHE	5,090
4,390 OTHER TAXES	
4,400 PAYROLL TAXES	260,957
4,401 PAYROLL TAXES BI	9,134
4,410 GROUP INSURANCE	269,107
4,420 LIABILITY INSURAN	79,254
4,430 WORKMAN'S COMP	74,279
4,435 W/C-FIRST AID CLA	387
4,436 DRUG TESTING MEI	1,917
4,450 MANAGEMENT FEE	302,033
4,460 BAD DEBTS	9,600
4,461 BAD DEBTS	22,088
4,470 LOST ITEMS-RESIDE	0
4,475 UNIFORM EXP/PERS	298
4,486 SERVICE CONTRAC	37,060
4,490 MISC EXPENSE	372
4,496 MISC. M.I.S. EXPENS	8,766
4,510 REAL ESTATE TAXE	0
4,600 LEASED EQUIPMEN	10,189
5,110 MAINTENANCE WA	92,788
5,120 MAINTENANCE PTO	7,678
5,130 ELECTRIC	51,008
5,131 NATURAL GAS	28,677
5,133 WATER & SEWER	26,129
5,134 TRASH COLLECTION	11,596
5,140 PROP/PLANT REPL,M	7,261
5,160 GENERAL REPAIR &	49,501
5,165 MAINTENANCE CON	35,542
5,210 DIETARY WAGES	245,018
5,220 DIETARY PTO & RES	18,663
5,248 FOOD PURCHASES	195,517

5,250 SUPPLIES DISHWAS	3,667
5,260 REPLACEMENT-DIE	4,485
5,270 KITCHEN SUPPLIES	9,176
5,295 MEAL INCOME	(6,023)
5,310 LAUNDRY WAGES	62,976
5,340 LAUNDRY PTO & RE	4,620
5,370 REPLACEMENT-LAU	12,219
	650
5,390 SUPPLIES	4,274
5,410 HOUSEKEEPING WA	95,440
5,440 HOUSEKEEPING PTC	10,950
5,480 SUPPLIES-CLEANIN	33,450
5,490 SUPPLIES-HOUSEKE	15
6,020 RN WAGES	464,415
6,030 DON WAGES	62,943
6,035 ADON WAGES	82,001
6,040 RN PTO & RESERVE	47,784
6,120 LPN WAGES	452,314
6,140 LPN PTO & RESERVI	30,557
6,220 AIDES WAGES	848,500
6,240 AIDES PTO & RESER	43,727
6,245	
	0
	384
	0
6,270 REHAB WAGES	39,873
6,275 REHAB PTO & RESE	4,069
6,290 NURSING SUPPLIES	185,216
6,295 NURSING SUPPLIES	27,436
6,390 REPLACEMENT-NUI	4,605
6,490 OTHER	3,629

7,280 DRUG PURCHASES-I	420,878
7,281 DRUG PURCHASES-0	305,468
7,380 LABORATORY SERV	0
7,390 X-RAY SERVICES E	54,300
7,510 ACTIVITIES WAGES	55,824
7,540 ACTIVITIES PTO & F	3,793
7,590 ACTIVITIES SUPPLI	2,596
7,620 PHYSICAL THERAPY	324,378
7,660 P.T. SUPPLY - BILLA	192
7,710 SOCIAL SERVICE W.	62,265
7,720 SOCIAL SERVICE PT	4,120
7,730 SOCIAL SERVICE-EXPENSES	
7,740 OCCUPATIONAL TH	255,646
7,770 SPEECH THERAPY F	98,737
7,820 BEAUTICIAN FEE	0
	0
	0
8,120 INTEREST	0
	29,941
8,130 DEPRECIATION	0
	0
9,510 INTEREST INCOME	(1,148)
9,520 MISC NON-OPERATI	0
4,220	0
8,100	486,182
9,702	0
5,230	0
	<u>28,075</u>

Expenses Fixed Assets

