

Facility Name & ID Number Heritage Health Dwight

0050492 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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	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	16,824	10,917	2,900	30,641	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,824	10,917	2,900	30,641	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.25%

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 2,900

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL 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 Dwight

0050492

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	266,162	16,666		282,828		282,828	4,908	287,736		1
2	Food Purchase		229,058		229,058		229,058	28	229,086		2
3	Housekeeping	118,094	36,810		154,904		154,904	36	154,940		3
4	Laundry	63,953	10,583		74,536		74,536		74,536		4
5	Heat and Other Utilities			146,722	146,722		146,722	1,274	147,996		5
6	Maintenance	90,553	84,683	60,723	235,959		235,959	15,013	250,972		6
7	Other (specify):*										7
8	TOTAL General Services	538,762	377,800	207,445	1,124,007		1,124,007	21,259	1,145,266		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,829,694	181,089	13,578	2,024,361		2,024,361	(22,373)	2,001,988		10
10a	Therapy		651,017	490,047	1,141,064	(618,176)	522,888		522,888		10a
11	Activities	132,467	7,585		140,052		140,052		140,052		11
12	Social Services	9,568		3,612	13,180		13,180		13,180		12
13	CNA Training			130	130		130	874	1,004		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,971,729	839,691	518,167	3,329,587	(618,176)	2,711,411	(21,499)	2,689,912		16
	C. General Administration										
17	Administrative	78,030			78,030		78,030		78,030		17
18	Directors Fees										18
19	Professional Services			303,910	303,910		303,910	(284,773)	19,137		19
20	Dues, Fees, Subscriptions & Promotions			93,993	93,993	(50,370)	43,623	(15,866)	27,757		20
21	Clerical & General Office Expenses	232,576	25,604	14,620	272,800		272,800	293,703	566,503		21
22	Employee Benefits & Payroll Taxes			627,786	627,786		627,786	43,859	671,645		22
23	Inservice Training & Education			8,291	8,291		8,291	784	9,075		23
24	Travel and Seminar			11,061	11,061		11,061	(6,062)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,080	51,080		51,080	12,703	63,783		26
27	Other (specify):* Lost resident items			67,315	67,315		67,315	(67,200)	115		27
28	TOTAL General Administration	310,606	25,604	1,178,056	1,514,266	(50,370)	1,463,896	(22,852)	1,441,044		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,821,097	1,243,095	1,903,668	5,967,860	(668,546)	5,299,314	(23,092)	5,276,222		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			206,933	206,933		206,933	18,040	224,973			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,950	30,950		30,950	(1,430)	29,520			32
33	Real Estate Taxes			42,724	42,724		42,724		42,724			33
34	Rent-Facility & Grounds			210,000	210,000		210,000	5,258	215,258			34
35	Rent-Equipment & Vehicles			13,187	13,187		13,187	7,327	20,514			35
36	Other (specify):*											36
37	TOTAL Ownership			503,794	503,794		503,794	29,195	532,989			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					618,176	618,176	(33,433)	584,743			39
40	Barber and Beauty Shops			4,658	4,658		4,658		4,658			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					50,370	50,370		50,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			4,658	4,658	668,546	673,204	(33,433)	639,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,821,097	1,243,095	2,412,120	6,476,312		6,476,312	(27,330)	6,448,982			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 Dwight

0050492

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				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	(1,373)			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	(12,182)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(31,963)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,200)			24
25	Fund Raising, Advertising and Promotional	(22,665)			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)	\$ (135,383)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	108,053		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 108,053		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (27,330)		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

Heritage Health Dwight

ID# 0050492

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		(31,963)	19	22
23				23
24		(67,200)	27	24
25		(22,665)	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	Total		(121,828)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Dwight# 0050492

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	4,908	0	0	0	0	0	0	0	0	4,908	1
2	Food Purchase	0	0	28	0	0	0	0	0	0	0	0	28	2
3	Housekeeping	0	0	36	0	0	0	0	0	0	0	0	36	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,274	0	0	0	0	0	0	0	0	1,274	5
6	Maintenance	0	0	15,013	0	0	0	0	0	0	0	0	15,013	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	21,259	0	0	0	0	0	0	0	0	21,259	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	(22,951)	578	0	0	0	0	0	0	0	0	(22,373)	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	874	0	0	0	0	0	0	0	0	874	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	(22,951)	1,452	0	0	0	0	0	0	0	0	(21,499)	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	(31,963)	(270,433)	17,623	0	0	0	0	0	0	0	0	(284,773)	19
20	Fees, Subscriptions & Promotions	(22,665)	0	6,799	0	0	0	0	0	0	0	0	(15,866)	20
21	Clerical & General Office Expenses	0	0	293,703	0	0	0	0	0	0	0	0	293,703	21
22	Employee Benefits & Payroll Taxes	0	0	43,859	0	0	0	0	0	0	0	0	43,859	22
23	Inservice Training & Education	0	(140)	924	0	0	0	0	0	0	0	0	784	23
24	Travel and Seminar	(12,182)	0	6,120	0	0	0	0	0	0	0	0	(6,062)	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	12,703	0	0	0	0	0	0	0	0	12,703	26
27	Other (specify):*	(67,200)	0	0	0	0	0	0	0	0	0	0	(67,200)	27
28	TOTAL General Administration	(134,010)	(270,573)	381,731	0	0	0	0	0	0	0	0	(22,852)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(134,010)	(293,524)	404,442	0	0	0	0	0	0	0	0	(23,092)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Dwight

0050492

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	0	0	18,040	0	0	0	0	0	0	0	18,040	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,373)	0	0	(57)	0	0	0	0	0	0	0	(1,430)	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	5,258	0	0	0	0	0	0	0	5,258	34
35	Rent-Equipment & Vehicles	0	0	0	7,327	0	0	0	0	0	0	0	7,327	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,373)	0	0	30,568	0	29,195	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	(33,433)	0	0	0	0	0	0	0	0	0	(33,433)	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	(33,433)	0	0	0	0	0	0	0	0	0	(33,433)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(135,383)	(326,957)	404,442	30,568	0	(27,330)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy	0.00%	\$ (22,951)	\$ (22,951)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(140)	(140)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(33,433)	(33,433)	3
4	V	19 Adjustment for Related Organization	270,433	Heritage Operations Group, LLC	0.00%		(270,433)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 270,433			\$ (56,524)	\$ * (326,957)	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.		\$	\$ 4,908	15
16	V	2 Food Purchase					28	16
17	V	3 Housekeeping					36	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,274	19
20	V	6 Maintenance					15,013	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					578	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					874	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					17,623	31
32	V	20 Fees, Subscription, Promotions					6,799	32
33	V	21 Clerical & General Office Expenses					293,703	33
34	V	22 Employee Benefits & Payroll Taxes					43,859	34
35	V	23 Inservice Training & Education					924	35
36	V	24 Travel and Seminar					6,120	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					12,703	38
39	Total		\$			\$	0	\$ * 404,442 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						18,040	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(57)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						5,258	20	
21	V	35 Rent-Equipment & Vehicles						7,327	21	
22	V	36 Other						0	22	
23	V	38 Medically Nec Transportation						0	23	
24	V	39 Ancillary Service Centers						0	24	
25	V	40 Barber and Beauty Shops						0	25	
26	V	41 Coffee and Gift Shops						0	26	
27	V	42 Other						0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	30,568	39

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

Facility Name & ID Number Heritage Health Dwight # 0050492 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 Dwight

0050492

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	92	\$ 4,908	1
2	2	Food Purchase	Beds	2,835	27	878	0	92	28	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	92	36	3
4	4	Laundry	Beds	2,835	27	0	0	92	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	92	1,274	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	92	15,013	6
7	7	Other	Beds	2,835	27	0	0	92	0	7
8	9	Medical Director	Beds	2,835	27	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	92	578	9
10	11	Activities	Beds	2,835	27	0	0	92	0	10
11	12	Social Service	Beds	2,835	27	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	92	874	12
13	14	Program Transportation	Beds	2,835	27	0	0	92	0	13
14	15	Other	Beds	2,835	27	0	0	92	0	14
15	17	Administrative	Beds	2,835	27	0	0	92	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	92	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	92	17,623	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	92	6,799	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	92	293,703	19
20	22	Employee Benefits & Payroll Tax	Beds	2,835	27	1,351,528	0	92	43,859	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	92	924	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	92	6,120	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0	92	12,703	24
25	TOTALS					\$ 12,462,987	\$ 8,837,683		\$ 404,442	25

Facility Name & ID Number Heritage Health Dwight

0050492

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	27	\$	\$	92	\$	1
2	30	Depreciation	Beds	2,835	27	555,915	92	18,040		2
3	31	Amortization of Pre-Op & Org	Beds	2,835	27		92			3
4	32	Interest	Beds	2,835	27	(1,746)	92	(57)		4
5	33	Real Estate Taxes	Beds	2,835	27		92			5
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022	92	5,258		6
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798	92	7,327		7
8	36	Other	Beds	2,835	27		92			8
9	38	Medically Nec Transportation	Beds	2,835	27		92			9
10	39	Ancillary Service Centers	Beds	2,835	27		92			10
11	40	Barber and Beauty Shops	Beds	2,835	27		92			11
12	41	Coffee and Gift Shops	Beds	2,835	27		92			12
13	42	Other	Beds	2,835	27		92			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	\$		\$ 30,568	25

Facility Name & ID Number

Heritage Health Dwight

0050492

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	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Bank of America		x	Working Capital						30,950	6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 30,950	9							
B. Non-Facility Related*																		
10	Interest Income									(1,373)	10							
11											11							
12	Allocated Corporate									(57)	12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$ (1,430)	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 29,520	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2014 report.		\$ 49,729	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.)		\$ 45,099	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (4,630)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 47,354	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 42,724	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2010	48,641	8
	2011	49,214	9
	2012	48,327	10
	2013	47,362	11
	2014	45,099	12
	FOR BHF USE ONLY		
	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 Heritage Health Dwight COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 37853

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>050504483001</u>	_____	\$ 42,620.48	\$ 42,620.48
2. <u>050504483002</u>	_____	\$ 1,474.14	\$ 1,474.14
3. <u>050504483011</u>	_____	\$ 1,004.84	\$ 1,004.84
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>45,099.46</u>	\$ <u>45,099.46</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.**

Facility Name & ID Number Heritage Health Dwight

0050492 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,300 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				\$	1
2					2
3	TOTALS			\$	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	92			\$	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9	1992 Improvements	1992		8,456				
10	1993 Improvements	1993		586,243				
11	1994 Improvements	1994		12,874				
12	1995 Improvements	1995		496				
13	Water Heater	1996		7,350				
14	Interior Rehab (see attached)	1997		118,804				
15	Garbage Disposal	1997		983				
16								
17	Parking Lot	1998		2,717				
18	Interior Rehab	1998		17,242				
19								
20	Alarm Repair/Replacement	1999		1,120				
21	Air Conditioning Unit	1999		2,461				
22	Shower Room Repair	1999		6,345				
23								
24	Fire Dampers	2000		1,290				
25	Boiler	2000		1,540				
26								
27	Water Heater	2001		7,200				
28	Window Replacements	2001		4,437				
29	Flooring -- Kitchen	2001		604				
30	Code Alert System	2001		933				
31	Motor Reolacement--A/C	2001		1,398				
32								
33	C/O Allocation				18,040		18,040	
34	Book Depreciation				130,385		130,385	
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	A/C compressor	2002	\$ 582	\$		\$	\$	\$	37
38	Boiler Tubing	2002	11,208						38
39	Backflow preventor	2002	2,803						39
40	Wallcoverings	2002	21,813						40
41	Compressor	2002	1,175						41
42	Rooftop A/C unit	2002	20,169						42
43	adustment	2002	(9,766)						43
44	Wallcoverings	2003	1,528						44
45	Rooftop A/C unit	2003							45
46	Exterior Doors	2003	3,121						46
47	30 Gallon Tank	2003	1,056						47
48	Compressor	2003	1,839						48
49	Walk in Freezer	2003	3,301						49
50	Disposal	2003	771						50
51									51
52	Fire Supression System	2004	1,523						52
53	Pump	2004	714						53
54	Boiler	2004	13,085						54
55	Water Softener	2004	1,467						55
56	Parking Lot Sealant	2004	2,800						56
57	Laundry drain	2004	2,350						57
58									58
59	Motor --Circulator	2005	1,674						59
60	Water Heater	2005	10,113						60
61	Kitchen Door	2005	240						61
62	A/C compressor	2005	175						62
63	Generator Panel	2005	833						63
64	Closet Rehab	2005	1,137						64
65	Exterior Lights	2005	127						65
66		2005	4,597						66
67		2005	1,059						67
68		2005	7,450						68
69		2005	1,967						69
70	TOTAL (lines 4 thru 69)		\$ 893,404	\$ 148,425		\$ 148,425	\$	\$	70

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

Facility Name & ID Number Heritage Health Dwight

0050492

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 12A, Carried Forward		\$ 893,404	\$ 148,425		\$ 148,425	\$	\$	1
2	Inline exhaust	2006	2,465						2
3	A/C compressor	2006	8,093						3
4	Exhaust fan	2006	2,435						4
5	Roof	2006	97,870						5
6	Dayroom -- paint	2006							6
7	Sewer	2006	2,260						7
8									8
9	Dayroom -- paint	2007	10,633						9
10	In-sink Erator	2007	895						10
11	Rooftop A/C	2007	12,269						11
12	Window	2007	583						12
13	Water Softener	2007	17,709						13
14	Water Heater	2007	11,668						14
15	Exterior Panting	2007	14,215						15
16	Water Heater	2007	12,140						16
17	adjustments	2007	(3,034)						17
18	Boiler	2008	6,030						18
19	Kitchen/Restroom Upgrade	2008	3,989						19
20	HVAC Unit	2008	13,845						20
21	Resident Room/Corridor Painting	2008	4,275						21
22									22
23	Shower	2009	33,402						23
24	Sidewalk	2009	3,860						24
25	Dining room rehab: flooring, wallcovering & labor	2009	16,336						25
26	Nurse Call system	2009	257,238						26
27									27
28									28
29	Fire Alarm	2010	47,091						29
30	Storage Shed/garage	2010	40,207						30
31	Asphalt Drive/parking lot		35,536						31
32	Facility Remodel		813,560						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,358,974	\$ 148,425		\$ 148,425	\$	\$	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 12B, Carried Forward		\$ 2,358,974	\$ 148,425		\$ 148,425	\$	\$	1
2									2
3	Landscaping	2011	17,207						3
4	Facility Remodel	2011	99,642						4
5	Rooftop A/C	2011	16,547						5
6									6
7	Water heater	2012	13,186						7
8	Compressor	2012	6,742						8
9	Lighting Upgrade	2012	2,762						9
10									10
11	Rooftop A/C Units	2013	15,027						11
12									12
13	Rooftop AC Unit	2014	8,608						13
14	Install New Generator	2014	79,653						14
15	Roof Replacement-Partial	2014	23,796						15
16	Replace Water Heater	2014	13,400						16
17									17
18	Rooftop unit replacement - add Lennox; remove Trane	2015	12,936						18
19	Install amp disconnect to generator	2015	2,870						19
20	Replacment of condensor in mult zone compressor unit	2015	6,310						20
21	Purchase and installation of new dishwasher	2015	13,273						21
22	Upgrade of HVAC controls	2015	24,430						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)		\$ 2,715,363	\$ 148,425		\$ 148,425	\$	\$	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	\$ 814,610	\$ 69,275	\$ 69,275	\$		\$	71
72	Current Year Purchases	95,626						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 910,236	\$ 69,275	\$ 69,275	\$		\$	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		2009 Turtletop bus	2008	\$ 61,091	\$ 7,273	\$ 7,273	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,091	\$ 7,273	\$ 7,273	\$		\$	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)	\$ 3,686,690	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 224,973	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 224,973	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Heritage Health Dwight

0050492

Report Period Beginning: 01/01/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Dwight Continental Manor.

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:		92	3/2009	\$ 210,000	5	15	3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 210,000			7

10. Effective dates of current rental agreement:

Beginning 3/2014

Ending 3/2019

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

Fiscal Year Ending Annual Rent

12. /2016 \$ 210,000

13. /2017 \$ 210,000

14. /2018 \$ 210,000

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: \$ 13,187

Description: Televisions

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Health Dwight # 0050492 Report Period Beginning: 01/01/15 Ending: 12/31/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 179,260	\$		\$ 179,260	1
2	Licensed Speech and Language Development Therapist		hrs				56,795			56,795	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				227,613	59,220		286,833	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					591,797		591,797	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						26,379			26,379	13
14	TOTAL			\$			\$ 490,047	\$ 651,017		\$ 1,141,064	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 Dwight# 0050492Report 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	\$ 1,229	\$	1
2	Cash-Patient Deposits	12,716		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,090,782		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,047		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,775,656)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (633,882)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,763,767		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	971,328		16
17	Accumulated Depreciation (book methods)	(2,344,538)		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)	\$ 1,390,557	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 756,675	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 419,609	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,716		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,830		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,818		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,354		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>	27,400		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 747,727	\$	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)	\$ 747,727	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,948	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 756,675	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 203,474	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 203,474	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(194,526)	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)	\$ (194,526)	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)	\$ 8,948	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	\$ 3,642,405		1
2	Discounts and Allowances for all Levels	(82,705)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,559,700		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	1,597,525		6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,597,525		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	(327)		12
13	Barber and Beauty Care	6,512		13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs	1,097,487		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services	19,516		21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,123,188		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***	1,373		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,373		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,281,786		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,124,007		31
32	Health Care	3,329,587		32
33	General Administration	1,514,266		33
B. Capital Expense				
34	Ownership	503,794		34
C. Ancillary Expense				
35	Special Cost Centers	4,658		35
36	Provider Participation Fee			36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,476,312		40
41	Income before Income Taxes (line 30 minus line 40)**	(194,526)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (194,526)		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 Dwight

0050492

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	1,801	1,896	\$ 69,092	\$ 36.44	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	18,965	19,963	591,319	29.62	3
4	Licensed Practical Nurses	2,347	2,471	60,343	24.42	4
5	CNAs & Orderlies	68,678	72,293	992,913	13.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,172	5,444	116,027	21.31	8
9	Activity Director					9
10	Activity Assistants	9,793	10,308	132,467	12.85	10
11	Social Service Workers	3,239	3,409	9,568	2.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,357	25,639	266,162	10.38	15
16	Dishwashers					16
17	Maintenance Workers	5,666	5,964	90,553	15.18	17
18	Housekeepers	10,849	11,420	118,094	10.34	18
19	Laundry	5,919	6,231	63,953	10.26	19
20	Administrator	1,976	2,080	78,030	37.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,371	9,864	232,576	23.58	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)	168,133	176,982	\$ 2,821,097 *	\$ 15.94	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	10,800		36
37	Medical Records Consultant	1,686		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,626		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	3,612		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,724		49

C. CONTRACT NURSES

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

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

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

Facility Name & ID Number Heritage Health Dwight

0050492

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. \$ 50,370
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. \$ 1,201
- (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	1,229				1,009	1,009 PETTY C 1,229
1010	CASH IN BANK					1,100	1,100 ACCTS R 1,333,583
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. (242,801)
1100	ACCOUNTS RECEIVABLE	1,090,782				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 37,047
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	37,047				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 971,328
1409	LAND	0				1,460	(820,921)
1450	FURNITURE & EQUIPMENT	971,328				1,475	1,475 CODE AI 2,763,767
1460	ACCUM DEPR-FURN & EQU	-820,921				1,490	1,490 ACCUM] (1,523,617)
1475	BUILDING & IMPROVEMEN	2,763,767				1,530	1,530 RESIDEN 12,716
1490	ACCUM DEPR-BUILDING	-1,523,617				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	12,716				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (1,775,656)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (419,609)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-1,775,656				2,100	2,100 ACCRUE (99,799)
2010	ACCOUNTS PAYABLE	-419,609				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-99,799				2,110	2,110 ACCRUE (137,031)
2110	ACCRUED VACATION PAY	-137,031				2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(3,818)	
2125	FICA TAX PAYABLE	-3,818	-3,818	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	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(27,400)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	(47,354)	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-27,400		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	-47,354		2,512	2,512 DUE TO 1	(12,716)	
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	(203,474)	
2460	INCOME TAXES PAYABLE				net income	194,526	
2512	DUE TO RESIDENTS	-12,716					
2600	MORTGAGE PAYABLE	0			balance	<u>0</u>	
2650	EQUIPMENT LOAN PAYABLE						
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-203,474					
2970	PROFIT/LOSS FOR PERIOD	194,526					
3007.1	PATIENT DAYS-PRIVATE	10,917					3,007

3007.2	PATIENT DAYS-IPA	16,824						3,007
3007.3	PATIENT DAYS-MEDICARE	2,900						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 &	-3,549,974	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	-67,834	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	-1,097,487	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,597,525	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	82,705	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	-6,512		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	1,083		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-756		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-24,597		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-19,516		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	212,721	232,576	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	78,030	78,030	17	1	0	0		4,120
4115	VACATION & SICK - G&A	19,855		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	15,754	627,786	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	4,494		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	-5,677		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	25,604	25,604	21	2	0	0		4,275
4260	TELEPHONE	14,620	14,620	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	8,291	8,291	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	7,285	11,061	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	651		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	3,125		24	3	19	-12,182 ***		4,289
4290	HELP WANTED ADVERTISING	9,417	93,993	20	3	0	0 -50,370		4,290
4291	PROMOTIONAL ADVERTISING	6,383		20	3	25	-6,383		4,291
4292	PUBLIC RELATIONS	12,646		20	3	25	-12,646		4,292
4300	LICENSES & FEES	55,669		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	7,659		20	3	17	-3,636		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	33,477	303,910	19	3	22	-31,963		4,350
4355	MEDICAL DIRECTOR	10,800	10,800	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	1,686		10	3	0	0	4,364
4363	PHARMACIST FEES	5,626		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,612	3,612	12	3	0	0	4,383
4370	TV RENTAL	11,172		35	3	5	0	4,390
4380	INCOME TAXES		67,315	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,219		20	3	26	0	4,401
4400	PAYROLL TAXES	253,494		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,100		22	3	0	0	4,420
4410	GROUP INSURANCE	299,074		22	3	0	0	4,430
4420	LIABILITY INSURANCE	51,080	51,080	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	52,547		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	270,433		19	3	34	0 **	4,460
4460	BAD DEBTS	67,200		27	3	24	-67,200	4,461
4470	LOST ITEMS-RESIDENTS	115		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	42,724	42,724	33	3	0	0	4,486
4600	LEASED EQUIPMENT	2,015	13,187	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	85,586	90,553	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,967		6	1	0	0	4,510
5130	ELECTRIC	46,462	146,722	5	3	0	0	4,600
5131	NATURAL GAS	23,444		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	76,816		5	3	0	0	5,130
5134	TRASH COLLECTION	9,013	60,723	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	17,685	84,683	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	66,998		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	51,710		6	3	0	0	5,140
5210	DIETARY WAGES	249,803	266,162	1	1	0	0	5,160
5220	DIETARY SICK & VAC	16,359		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	230,259	229,058	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	4,221	16,666	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	2,051		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	10,394		1	2	0	0	5,260
5295	MEAL CREDIT	-1,201		2	2	0	0	5,270
5310	LAUNDRY WAGES	59,975	63,953	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,978		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	3,718	10,583	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	6,865		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	113,001	118,094	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	5,093		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	36,810	36,810	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	0		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,829,694	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	551,959		10	1	0	0	6,020
6030	DON WAGES	69,092		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	39,360		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	56,933		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	3,410		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	939,508		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	53,405		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	1,673		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	130	130	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	106,624		10	1	0	0	6,390
6275	REHAB SICK & VAC	9,403		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	101,552	181,089	10	2	0	0	7,281
6295	NURSING SUPPLIES	61,589		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	17,948		10	2	0	0	7,391
6490	NURSING OTHER	4,593	13,578	10	3	0	0	7,393
7280	DRUG PURCHASES	212,512	651,017	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	379,285		39	2			7,540
7380	LABORATORY SERVICES	26,379	490,047	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	125,276	132,467	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	7,191		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	7,585	7,585	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	227,613		39	3	0	0 ***	7,890
7660	PT SUPPLIES	59,220		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	9,568	9,568	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	0		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	179,260		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	56,795		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	4,658	4,658	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	210,000	210,000	34	3	0	0	

8120	INTEREST EXPENSE	30,950	30,950	32	3	14	-1,373	
8130	DEPRECIATION	206,933	206,933	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-1,373		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		6,474,939	6,476,312					
			1,373					

GRAND TOTALS 194,526 -135,383
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

PP 10,917
IPA 16,824
medicare 2,900

RECAP CENSUS

10,917
16,824
2,900
30,641

UND

RIA

BT

BT

3,007 PATIENT	16,824
3,007 PATIENT	2,900
	0

3,010 BASIC CI (3,549,974)

3,020 BASIC CI 0

3,030 BASIC CI 0

0

0

0

0

3,080 NURSING (67,834)

3,081 NURSING 0

3,082 NURSING 0

3,083 NURSING 0

3,100 DRUGS-M (1,097,487)

0

3,110 PHYSICIAN (1,597,525)

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 INCOME	
3,530 BEAUTY	(6,512)
	1,083
3,570 VENDING	(756)
3,590 EQUIPMI	(24,597)
3,595 RESIDEN	(19,516)
3,600 MISC INC	0
4,110 G&A WA	212,721
4,111 ADMINIS	78,030
4,115 G&A PTC	19,855
4,120 EMPLOY	15,153
4,130 EMPLOY	4,494
4,135 EMPLOY	(5,677)
4,250 OFFICE S	12,763
4,255 POSTAGI	3,707
4,260 TELEPHC	14,620
4,275 TRAININ	8,291
	0
4,280 GENERA	7,285
4,281 MEAL EX	651
4,285 EDUCAT	3,125
4,289 MEETINGS EXPENSE	
4,290 HELP WA	9,417
4,291 PROMOT	6,383
4,292 PUBLIC I	12,646
4,300 LICENSE	55,669
4,310 DUES & F	7,659
4,320 CONTRIBUTIONS	
4,350 PROFESS	33,477
4,355 MEDICAL	10,800
	1,686
	5,626

4,364 SOCIAL S	3,612
4,370 TV RENT	11,172
4,383 BACKGR	2,219
4,390 OTHER TAXES	
4,400 PAYROL	253,494
4,401 PAYROL	8,100
4,410 GROUP I	299,074
4,420 LIABILIT	51,080
4,430 WORKM	50,213
4,435 W/C-FIRS	751
4,436 DRUG TE	1,583
4,450 MANAGI	270,433
4,460 BAD DEF	67,200
4,461 BAD DEF	82,705
4,470 LOST ITE	115
4,475 UNIFORM	601
4,486 SERVICE	33,550
4,490 MISC EX	880
4,496 MISC. M.	9,134
4,510 REAL ES	42,724
4,600 LEASED	2,015
5,110 MAINTEI	85,586
5,120 MAINTEI	4,967
5,130 ELECTRI	46,462
5,131 NATURA	23,444
5,133 WATER &	76,816
5,134 TRASH C	9,013
5,140 PROP/PL	17,685
5,160 GENERA	66,998
5,165 MAINTEI	18,160
5,210 DIETARY	249,803
5,220 DIETARY	16,359
5,248 FOOD PU	229,379

5,250 SUPPLIE	4,221
5,260 REPLACI	2,051
5,270 KITCHEN	10,394
5,295 MEAL IN	(1,201)
5,310 LAUNDR	59,975
5,340 LAUNDR	3,978
5,370 REPLACI	3,718
	0
5,390 SUPPLIE	6,865
5,410 HOUSEK	113,001
5,440 HOUSEK	5,093
5,480 SUPPLIE	36,810
5,490 SUPPLIES-HOUSEKEEPING	
6,020 RN WAG	551,959
6,030 DON WA	69,092
6,035 ADON WAGES	
6,040 RN PTO &	39,360
6,120 LPN WAG	56,933
6,140 LPN PTO	3,410
6,220 AIDES W	939,508
6,240 AIDES PT	53,405
6,245	1,673
	0
	130
	0
6,270 REHAB V	106,624
6,275 REHAB F	9,403
6,290 NURSINC	101,552
6,295 NURSINC	61,589
6,390 REPLACI	17,948
6,490 OTHER	4,593

7,280 DRUG PU	212,512
7,281 DRUG PU	379,285
7,380 LABORA	4,141
7,390 X-RAY S	22,238
	0
7,510 ACTIVIT	125,276
7,540 ACTIVIT	7,191
7,590 ACTIVIT	7,585
7,620 PHYSICA	227,613
7,660 P.T. SUPE	59,220
7,710 SOCIAL S	9,568
7,720 SOCIAL SERVICE PTO & RESERVE	
7,730 SOCIAL S	0
7,740 OCCUPA	179,260
7,770 SPEECH '	56,795
7,820 BEAUTIC	4,658
	0
	0
8,120 INTERES	0
	30,950
8,130 DEPRECI	206,933
	0
9,510 INTERES	(1,373)
9,520 MISC NO	0
4,220	0
8,100	210,000
9,702	0
5,230	0
	<u>194,526</u>

Expenses Fixed Assets

