

Facility Name & ID Number Heritage Health Streator

0048066 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	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	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	28,042	14,207	690	42,939	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,042	14,207	690	42,939	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.49%

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 690

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 Streator

0048066

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	567,900	22,647		590,547		590,547	6,935	597,482		1
2	Food Purchase		111,557		111,557		111,557	40	111,597		2
3	Housekeeping	159,539	91,487		251,026		251,026	50	251,076		3
4	Laundry	82,101	26,064		108,165		108,165		108,165		4
5	Heat and Other Utilities			157,786	157,786		157,786	1,800	159,586		5
6	Maintenance	97,274	82,994	90,493	270,761		270,761	21,214	291,975		6
7	Other (specify):*										7
8	TOTAL General Services	906,814	334,749	248,279	1,489,842		1,489,842	30,039	1,519,881		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	2,848,160	215,769	10,338	3,074,267		3,074,267	(40,030)	3,034,237		10
10a	Therapy		916,260	892,905	1,809,165	(966,479)	842,686		842,686		10a
11	Activities	84,283	4,023		88,306		88,306		88,306		11
12	Social Services	45,669	745	3,795	50,209		50,209		50,209		12
13	CNA Training	12,536	1,820		14,356		14,356	1,235	15,591		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,990,648	1,138,617	909,438	5,038,703	(966,479)	4,072,224	(38,795)	4,033,429		16
	C. General Administration										
17	Administrative	110,000			110,000		110,000		110,000		17
18	Directors Fees										18
19	Professional Services			423,736	423,736		423,736	(399,189)	24,547		19
20	Dues, Fees, Subscriptions & Promotions			118,796	118,796	(71,175)	47,621	(16,173)	31,448		20
21	Clerical & General Office Expenses	278,394	23,615	8,310	310,319		310,319	415,015	725,334		21
22	Employee Benefits & Payroll Taxes			876,496	876,496		876,496	61,975	938,471		22
23	Inservice Training & Education			9,704	9,704		9,704	1,145	10,849		23
24	Travel and Seminar			11,055	11,055		11,055	(6,056)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,441	65,441		65,441	17,950	83,391		26
27	Other (specify):*			59,029	59,029		59,029	(58,879)	150		27
28	TOTAL General Administration	388,394	23,615	1,572,567	1,984,576	(71,175)	1,913,401	15,788	1,929,189		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,285,856	1,496,981	2,730,284	8,513,121	(1,037,654)	7,475,467	7,032	7,482,499		29

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

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

Facility Name & ID Number

Heritage Health Streator

#0048066

Report Period Beginning:

01/01/15

Ending:

12/31/15

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							300,613	300,613			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,735	43,735		43,735	119,179	162,914			32
33	Real Estate Taxes							63,649	63,649			33
34	Rent-Facility & Grounds			569,400	569,400		569,400	(561,970)	7,430			34
35	Rent-Equipment & Vehicles			30,582	30,582		30,582	10,354	40,936			35
36	Other (specify):*											36
37	TOTAL Ownership			643,717	643,717		643,717	(68,175)	575,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					966,479	966,479	(107,860)	858,619			39
40	Barber and Beauty Shops		1,039	16,180	17,219		17,219		17,219			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					71,175	71,175		71,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,039	16,180	17,219	1,037,654	1,054,873	(107,860)	947,013			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,285,856	1,498,020	3,390,181	9,174,057		9,174,057	(169,003)	9,005,054			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 Streator

0048066

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	(341)			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	(14,704)			19
20	Contributions	(1,279)			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	(57,600)			24
25	Fund Raising, Advertising and Promotional	(25,781)			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)	\$ (104,237)		\$	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)	(64,766)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (64,766)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (169,003)		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 Streator

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

ID# 0048066

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(1,279)	27	20
21				21
22		(4,532)	19	22
23				23
24		(57,600)	27	24
25		(25,781)	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		(89,192)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Streator# 0048066

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	6,935	0	0	0	0	0	0	0	0	6,935	1
2	Food Purchase	0	0	40	0	0	0	0	0	0	0	0	40	2
3	Housekeeping	0	0	50	0	0	0	0	0	0	0	0	50	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,800	0	0	0	0	0	0	0	0	1,800	5
6	Maintenance	0	0	21,214	0	0	0	0	0	0	0	0	21,214	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	30,039	0	30,039	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	(40,847)	817	0	0	0	0	0	0	0	0	(40,030)	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	1,235	0	0	0	0	0	0	0	0	1,235	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	(40,847)	2,052	0	(38,795)	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)	(419,559)	24,902	0	0	0	0	0	0	0	0	(399,189)	19
20	Fees, Subscriptions & Promotions	(25,781)	0	9,608	0	0	0	0	0	0	0	0	(16,173)	20
21	Clerical & General Office Expenses	0	0	415,015	0	0	0	0	0	0	0	0	415,015	21
22	Employee Benefits & Payroll Taxes	0	0	61,975	0	0	0	0	0	0	0	0	61,975	22
23	Inservice Training & Education	0	(160)	1,305	0	0	0	0	0	0	0	0	1,145	23
24	Travel and Seminar	(14,704)	0	8,648	0	0	0	0	0	0	0	0	(6,056)	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	17,950	0	0	0	0	0	0	0	0	17,950	26
27	Other (specify):*	(58,879)	0	0	0	0	0	0	0	0	0	0	(58,879)	27
28	TOTAL General Administration	(103,896)	(419,719)	539,403	0	15,788	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(103,896)	(460,566)	571,494	0	7,032	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Streator

0048066

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	275,121	0	25,492	0	0	0	0	0	0	0	300,613	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(341)	119,600	0	(80)	0	0	0	0	0	0	0	119,179	32
33	Real Estate Taxes	0	63,649	0	0	0	0	0	0	0	0	0	63,649	33
34	Rent-Facility & Grounds	0	(569,400)	0	7,430	0	0	0	0	0	0	0	(561,970)	34
35	Rent-Equipment & Vehicles	0	0	0	10,354	0	0	0	0	0	0	0	10,354	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(341)	(111,030)	0	43,196	0	(68,175)	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	(107,860)	0	0	0	0	0	0	0	0	0	(107,860)	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	(107,860)	0	0	0	0	0	0	0	0	0	(107,860)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(104,237)	(679,456)	571,494	43,196	0	(169,003)	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	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	<u>10 Adjustment for Related Organization</u>	\$	<u>GreenTree Pharmacy</u>	<u>0.00%</u>	\$ <u>(40,847)</u>	\$ <u>(40,847)</u>	1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(160)</u>	<u>(160)</u>	2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(107,860)</u>	<u>(107,860)</u>	3
4	V	<u>19 Adjustment for Related Organization</u>	<u>419,559</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(419,559)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>569,400</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(569,400)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>63,649</u>	<u>63,649</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>114,827</u>	<u>114,827</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>275,121</u>	<u>275,121</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 988,959			\$ 309,503	\$ * (679,456)	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.		\$	\$ 6,935	15
16	V	2 Food Purchase					40	16
17	V	3 Housekeeping					50	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,800	19
20	V	6 Maintenance					21,214	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					817	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,235	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					24,902	31
32	V	20 Fees, Subscription, Promotions					9,608	32
33	V	21 Clerical & General Office Expenses					415,015	33
34	V	22 Employee Benefits & Payroll Taxes					61,975	34
35	V	23 Inservice Training & Education					1,305	35
36	V	24 Travel and Seminar					8,648	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					17,950	38
39	Total		\$			\$	0	\$ * 571,494 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						25,492	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(80)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						7,430	20	
21	V	35 Rent-Equipment & Vehicles						10,354	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	\$ *	43,196	39

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

Facility Name & ID Number Heritage Health Streator # 0048066 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 Streator

0048066 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	130	\$ 6,935	1
2	2	Food Purchase	Beds	2,835	27	878	0	130	40	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	130	50	3
4	4	Laundry	Beds	2,835	27	0	0	130	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	130	1,800	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	130	21,214	6
7	7	Other	Beds	2,835	27	0	0	130	0	7
8	9	Medical Director	Beds	2,835	27	0	0	130	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	130	817	9
10	11	Activities	Beds	2,835	27	0	0	130	0	10
11	12	Social Service	Beds	2,835	27	0	0	130	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	130	1,235	12
13	14	Program Transportation	Beds	2,835	27	0	0	130	0	13
14	15	Other	Beds	2,835	27	0	0	130	0	14
15	17	Administrative	Beds	2,835	27	0	0	130	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	130	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	130	24,902	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	130	9,608	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	130	415,015	19
20	22	Employee Benefits & Payroll Tax	Beds	2,835	27	1,351,528	0	130	61,975	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	130	1,305	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	130	8,648	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0	130	17,950	24
25	TOTALS					\$ 12,462,987	\$ 8,837,683		\$ 571,494	25

Facility Name & ID Number Heritage Health Streator

0048066 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

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

Name of Related Organization See Pg 8
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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	\$	\$	130	\$	1
2	30	Depreciation	Beds	2,835	27	555,915	130	25,492		2
3	31	Amortization of Pre-Op & Org	Beds	2,835	27		130			3
4	32	Interest	Beds	2,835	27	(1,746)	130	(80)		4
5	33	Real Estate Taxes	Beds	2,835	27		130			5
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022	130	7,430		6
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798	130	10,354		7
8	36	Other	Beds	2,835	27		130			8
9	38	Medically Nec Transportation	Beds	2,835	27		130			9
10	39	Ancillary Service Centers	Beds	2,835	27		130			10
11	40	Barber and Beauty Shops	Beds	2,835	27		130			11
12	41	Coffee and Gift Shops	Beds	2,835	27		130			12
13	42	Other	Beds	2,835	27		130			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	\$	43,196		25

Facility Name & ID Number

Heritage Health Streator

0048066

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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bank of America		x	Mortgage			\$	\$			\$ 114,827	1					
2	Bank of America		x	Loan Fee Amortization							4,773	2					
3												3					
4												4					
5												5					
Working Capital																	
6	Bank of America		x	Working Capital							43,735	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$			\$ 163,335	9					
B. Non-Facility Related*																	
10	Interest Income										(341)	10					
11												11					
12	Allocated Corporate										(80)	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (421)	14					
15	TOTALS (line 9+line14)						\$	\$			\$ 162,914	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.)

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 48066

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>34-31-134-000</u>	_____	\$ <u>63,649.12</u>	\$ <u>63,649.12</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>63,649.12</u></u>	\$ <u><u>63,649.12</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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 Streator

0048066 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,770 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).

Evergreen Place-Streator - (53) unit supportive living facility - grounds are adjacent but separate

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				\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	130			\$ 348,848	\$		\$	\$	4
5				440,122					5
6				2,594,839					6
7									7
8									8
Improvement Type**									
9									9
10									10
11	1980 Improvements		1980	12,172					11
12	1981 Improvements		1981	13,748					12
13	1982 Improvements		1982	18,366					13
14	1983 Improvements		1983	9,250					14
15	1984 Improvements		1984	1,329					15
16	1985 Improvements		1985	4,100					16
17	1986 Improvements		1986	57,336					17
18	1988 Improvements		1987	6,225					18
19	1989 Improvements		1988	48,818					19
20	1990 Improvements		1989	22,687					20
21	1991 Improvements		1990	31,584					21
22	1992 Improvements		1991	3,560					22
23	1993 Improvements		1992	19,172					23
24	1994 Improvements		1993	23,135					24
25	1995 Improvements		1994	22,036					25
26	BOILER		1995	39,228					26
27	EXHAUST HOOD		1996	3,910					27
28									28
29									29
30									30
31									31
32									32
33	C/O Allocation				25,492		25,492		33
34	Book Depreciation				201,209		201,209		34
35									35
36									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$	37
38	Roof	1997	5,232						38
39	Sprinkler System	1997	9,530						39
40	Code Alert	1997	1,879						40
41									41
42	Code Alert	1998	2,000						42
43	Bathroom Door	1998	656						43
44	Interior Rehab	1998	11,815						44
45									45
46	Door Alarms	1999	3,675						46
47									47
48	Water Heater	2000	4,114						48
49	Exhaust Fans	2000	931						49
50	Booster Heater -- Water Heater	2000	1,465						50
51									51
52	Professional Fees---Building Renovation	2001	27,964						52
53	Sprinkler Replacement	2001	4,955						53
54	AC Unit with Installation	2001	4,372						54
55	Exterior Painting	2001	6,545						55
56	Code Alert System	2001	4,592						56
57									57
58	Roof	2002	48,840						58
59	Sewer line	2002	20,615						59
60	Condensing Unit	2002	1,213						60
61									61
62	Exterior Door	2003	6,556						62
63	Exit Lights	2003	1,013						63
64	Heating Pump	2003	1,746						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,177,147	\$ 226,701		\$ 226,701	\$	\$	70

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

Facility Name & ID Number Heritage Health Streator

0048066

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		\$ 4,177,147	\$ 226,701		\$ 226,701	\$	\$	1
2	Doors	2004	1,386						2
3	A/C	2004	5,061						3
4	PVC kickplate	2004	2,859						4
5	Disposal	2004	1,175						5
6									6
7	Roof	2005	54,596						7
8	A/C Condensing Unit	2005	5,800						8
9	Window Replacement	2005	51,893						9
10	Water Main	2005	1,706						10
11									11
12									12
13	Roof	2006	19,500						13
14	A/C Replacement	2006	1,974						14
15	Boiler	2006	58,327						15
16	Landscapping	2006	5,398						16
17									17
18	Nurse's station	2007	9,580						18
19	Nurse call system	2007	96,193						19
20	Wireless network	2007	26,272						20
21	Corridor Paint and floors	2007	37,819						21
22	A/C	2007	23,747						22
23	Wander guard	2007	4,177						23
24	Garage --Construction of new Maintenance Garage	2007	42,453						24
25	Professional Fee -- remodel	2007	1,286						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,628,349	\$ 226,701		\$ 226,701	\$	\$	34

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

Facility Name & ID Number Heritage Health Streator

0048066

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		\$ 4,628,349	\$ 226,701		\$ 226,701	\$	\$	1
2	Landscaping	2008	22,238						2
3	Garage --Construction of new Maintenance Garage	2008	9,644						3
4	South Wing Windows	2008	63,040						4
5	Air Handler	2008	10,301						5
6	Redo North Nurses Station	2008	8,101						6
7									7
8	Wireless Network	2009	4,035						8
9	South Dining Room Electric	2009	2,752						9
10	Corridor Doors	2009	22,230						10
11									11
12	Lennox condensor	2010	6,864						12
13	Walkin Cooler	2010	4,313						13
14	Nurse Call System	2010	6,594						14
15	Wood Blinds	2010	2,914						15
16									16
17									17
18	Trane Air Handler	2011	58,281						18
19	Trane Rooftop Unit	2011	3,017						19
20	Gas Water Heater	2011	4,352						20
21	Air Condition Coils	2011	7,904						21
22	Water Heater	2011	4,352						22
23	Wiring & Installation	2011	7,546						23
24	Sealer & Coating	2011	8,985						24
25	Sign	2011	2,650						25
26									26
27	Goodman Condensing Unit	2012	9,494						27
28	Flooring Replacement	2012	176,220						28
29	GFI & Receptical	2012	4,158						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,078,334	\$ 226,701		\$ 226,701	\$	\$	34

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

Facility Name & ID Number Heritage Health Streator

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		\$ 5,078,334	\$ 226,701		\$ 226,701	\$	\$	1
2									2
3	Lighting Retrofit-Facility wide replacement of ballasts and bulbs	2013	8,250						3
4	Renovation of rooms & hallways in corridors 300 & 400	2013	229,287						4
5	(Removal and replacement of flooring and cabinets; painting)	2014	87,266						5
6									6
7	Renovation of rooms & hallways in corridors 100 & 200								7
8	(Removal and replacement of flooring and cabinets; painting)	2014	235,862						8
9	Water Heater Replacement	2014	17,378						9
10	Install Electric Door	2014	6,242						10
11	Parking Lot Fill and Seal	2014	6,863						11
12									12
13	Installed (2) new hot water heater expansion tanks	2015	3,785						13
14	Install electric heat in air handlers - NE and NW wings	2015	9,295						14
15	Completion of 2014 renovation to corridors 100&200 - asbestos abatement	2015	3,650						15
16									16
17	Replace (4) wood doors	2015	3,440						17
18	Flooring replacement - Rec Room	2015	5,334						18
19	Nurse call system upgrade - telephonic and electrical upgrades	2015	33,961						19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,728,947	\$ 226,701		\$ 226,701	\$	\$	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	\$	\$ 66,520	\$ 66,520	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$ 66,520	\$ 66,520	\$		\$	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	\$ 62,091	\$ 7,392	\$ 7,392	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 62,091	\$ 7,392	\$ 7,392	\$		\$	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)	\$ 5,841,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,613	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,613	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 Streator

0048066

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: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2016	\$ _____
-----	-------------	----------

13.	_____ /2017	\$ _____
-----	-------------	----------

14.	_____ /2018	\$ _____
-----	-------------	----------

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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	\$			\$ 400,835	\$		\$ 400,835	1
2	Licensed Speech and Language Development Therapist		hrs				47,686			47,686	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				392,639	1,526		394,165	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					914,734		914,734	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						51,745			51,745	13
14	TOTAL			\$			\$ 892,905	\$ 916,260		\$ 1,809,165	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 Streator

0048066

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	\$ 1,716	\$	1
2	Cash-Patient Deposits	12,858		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,873,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,974		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(148,048)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,782,613	\$	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)	\$ 1,782,613	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 507,691	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,859		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,552		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,794		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>	36,153		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 880,049	\$	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)	\$ 880,049	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 902,564	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,782,613	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 283,589	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 283,589	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	618,975	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)	\$ 618,975	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)	\$ 902,564	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	\$ 4,908,887	1	
2	Discounts and Allowances for all Levels	(79,296)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,829,591	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	3,238,014	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,238,014	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	19,967	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,686,193	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	18,926	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,725,086	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	341	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 341	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)	\$ 9,793,032	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,489,842	31	
32	Health Care	5,038,703	32	
33	General Administration	1,984,576	33	
B. Capital Expense				
34	Ownership	643,717	34	
C. Ancillary Expense				
35	Special Cost Centers	17,219	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)*	\$ 9,174,057	40	
41	Income before Income Taxes (line 30 minus line 40)**	618,975	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 618,975	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 Streator

0048066

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	1,807	1,902	\$ 71,456	\$ 37.57	1
2	Assistant Director of Nursing	1,773	1,866	59,703	32.00	2
3	Registered Nurses	21,624	22,762	698,988	30.71	3
4	Licensed Practical Nurses	19,307	20,323	567,266	27.91	4
5	CNAs & Orderlies	89,562	94,276	1,381,334	14.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,330	2,453	69,413	28.30	8
9	Activity Director					9
10	Activity Assistants	5,721	6,022	84,283	14.00	10
11	Social Service Workers	1,947	2,049	45,669	22.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	51,381	54,085	567,900	10.50	15
16	Dishwashers					16
17	Maintenance Workers	6,036	6,354	97,274	15.31	17
18	Housekeepers	15,042	15,834	159,539	10.08	18
19	Laundry	6,894	7,257	82,101	11.31	19
20	Administrator	1,976	2,080	110,000	52.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,806	13,480	278,394	20.65	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)	238,206	250,743	\$ 4,273,320 *	\$ 17.04	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	2,400		36
37	Medical Records Consultant	(344)		37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,742		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	3,795		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 13,593		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 Streator

0048066

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. \$ 71,175
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. \$ 246,767
- (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	1,716				1,009	1,009 PETTY C 1,716
1010	CASH IN BANK					1,100	1,100 ACCTS R 1,959,025
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. (85,912)
1100	ACCOUNTS RECEIVABLE	1,873,113				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 42,974
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	42,974				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 12,858
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	12,858				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (148,048)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (507,691)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-148,048				2,100	2,100 ACCRUE (61,294)
2010	ACCOUNTS PAYABLE	-507,691				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-61,294				2,110	2,110 ACCRUE (251,258)
2110	ACCRUED VACATION PAY	-251,258				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(10,794)	
2125	FICA TAX PAYABLE	-10,794	-10,794	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/H		
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	(36,153)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-36,153		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO	(12,859)	
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	(283,588)	
2460	INCOME TAXES PAYABLE				net income	(618,976)	
2512	DUE TO RESIDENTS	-12,859					
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	-283,588					
2970	PROFIT/LOSS FOR PERIOD	-618,976					
3007.1	PATIENT DAYS-PRIVATE	14,207					3,007

3007.2	PATIENT DAYS-IPA	28,042						3,007
3007.3	PATIENT DAYS-MEDICARE	690						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-4,782,663	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	-95,583	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	-1,686,193	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-3,238,014	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	79,296	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	-19,967		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	-30,641		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	-18,926		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	247,392	278,394	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	110,000	110,000	17	1	0	0		4,120
4115	VACATION & SICK - G&A	31,002		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	33,594	876,496	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	4,178		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	23,615	23,615	21	2	0	0		4,275
4260	TELEPHONE	8,310	8,310	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	9,704	9,704	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	8,007	11,055	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	67		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	2,981		24	3	19	-14,704 ***		4,289
4290	HELP WANTED ADVERTISING	6,050	118,796	20	3	0	0 -71,175		4,290
4291	PROMOTIONAL ADVERTISING	6,092		20	3	25	-6,092		4,291
4292	PUBLIC RELATIONS	13,609		20	3	25	-13,609		4,292
4300	LICENSES & FEES	76,440		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	11,240		20	3	17	-6,080		4,310
4320	CONTRIBUTIONS	1,279		27	3	20	-1,279		4,320
4350	PROFESSIONAL FEES	4,177	423,736	19	3	22	-4,532		4,350
4355	MEDICAL DIRECTOR	2,400	2,400	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	-344		10	3	0	0	4,364
4363	PHARMACIST FEES	7,742		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,795	3,795	12	3	0	0	4,383
4370	TV RENTAL	10,655		35	3	5	0	4,390
4380	INCOME TAXES		59,029	27	3	26	0	4,400
4383	BACKGROUND CHECKS	5,365		20	3	26	0	4,401
4400	PAYROLL TAXES	365,947		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	11,418		22	3	0	0	4,420
4410	GROUP INSURANCE	367,495		22	3	0	0	4,430
4420	LIABILITY INSURANCE	65,441	65,441	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	93,864		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	419,559		19	3	34	0 **	4,460
4460	BAD DEBTS	57,600		27	3	24	-57,600	4,461
4470	LOST ITEMS-RESIDENTS	150		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	19,927	30,582	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	89,217	97,274	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	8,057		6	1	0	0	4,510
5130	ELECTRIC	82,629	157,786	5	3	0	0	4,600
5131	NATURAL GAS	33,205		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	41,952		5	3	0	0	5,130
5134	TRASH COLLECTION	23,356	90,493	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	33,808	82,994	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	49,186		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	67,137		6	3	0	0	5,140
5210	DIETARY WAGES	530,962	567,900	1	1	0	0	5,160
5220	DIETARY SICK & VAC	36,938		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	358,324	111,557	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,970	22,647	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	2,083		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	16,594		1	2	0	0	5,260
5295	MEAL CREDIT	-246,767		2	2	0	0	5,270
5310	LAUNDRY WAGES	76,474	82,101	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	5,627		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	18,118	26,064	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	7,946		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	149,279	159,539	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	10,260		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	91,309	91,487	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	178		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,848,160	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	639,676		10	1	0	0	6,020
6030	DON WAGES	71,456		10	1	0	0	6,030
6035	ADON	59,703		10	1	0	0	6,035
6040	RN SICK & VACATION	59,312		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	512,852		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	54,414		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	1,285,718		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	95,616		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/	12,536	12,536	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	1,820	1,820	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	64,228		10	1	0	0	6,390
6275	REHAB SICK & VAC	5,185		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	71,496	215,769	10	2	0	0	7,281
6295	NURSING SUPPLIES	128,026		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	16,247		10	2	0	0	7,391
6490	NURSING OTHER	2,940	10,338	10	3	0	0	7,393
7280	DRUG PURCHASES	450,775	916,260	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	463,959		39	2			7,540
7380	LABORATORY SERVICES	51,745	892,905	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	75,499	84,283	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	8,784		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	4,023	4,023	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	392,639		39	3	0	0 ***	7,890
7660	PT SUPPLIES	1,526		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	42,699	45,669	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	2,970		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	745	745	12	2	0	0	8,130
7740	OT FEE	400,835		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	47,686		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	16,180	16,180	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	1,039	1,039	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	569,400	569,400	34	3	0	0	

8120	INTEREST EXPENSE	43,735	43,735	32	3	14	-341	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-341		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

9,173,716 9,174,057
341

GRAND TOTALS

-618,975 -104,237
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

G/L

RECAP CENSUS

PP	14,207	14,207
IPA	28,042	28,042
medicare	690	690
		42,939

UND

RIA

BT

BT

3,007 PATIENT 28,042
3,007 PATIENT 690
0

3,010 BASIC CI (4,782,663)

3,020 BASIC CI 0

3,030 BASIC CI 0

0

0

0

0

3,080 NURSING (95,583)

3,081 NURSING SUPPLIES-IPA

3,082 NURSING SUPPLIES-M/C A

3,083 NURSING 0

3,100 DRUGS-M (1,686,193)

3,110 PHYSICIAN (3,238,014)

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/OTH 0

3,411 MEDICAL 0

3,420 MEDICARE DISCOUNTS

3,520 RENT INCOME	
3,530 BEAUTY	(19,967)
	0
3,570 VENDING INCOME & EXPENSE	
3,590 EQUIPMI	(30,641)
3,595 RESIDEN	0
3,600 MISC INC	(18,926)
4,110 G&A WA	247,392
4,111 ADMINIS	110,000
4,115 G&A PTC	31,002
4,120 EMPLOY	33,449
4,130 EMPLOYEE SCHOLARSHIPS	
4,135 EMPLOY	4,178
4,250 OFFICE S	9,036
4,255 POSTAGI	4,679
4,260 TELEPHC	8,310
4,275 TRAININ	9,704
	0
4,280 GENERA	8,007
4,281 MEAL EX	67
4,285 EDUCAT	2,839
4,289 MEETINC	142
4,290 HELP WA	6,050
4,291 PROMOT	6,092
4,292 PUBLIC I	13,609
4,300 LICENSE	76,440
4,310 DUES & :	11,240
4,320 CONTRIE	1,279
4,350 PROFESS	4,177
4,355 MEDICAL	2,400
	(344)
	7,742

4,364 SOCIAL S	3,795
4,370 TV RENT	10,655
4,383 BACKGR	5,365
4,390 OTHER TAXES	
4,400 PAYROL	365,947
4,401 PAYROL	11,418
4,410 GROUP I	367,495
4,420 LIABILIT	65,441
4,430 WORKM.	90,303
4,435 W/C-FIRS	565
4,436 DRUG TE	2,996
4,450 MANAGI	419,559
4,460 BAD DEF	57,600
4,461 BAD DEF	79,296
4,470 LOST ITE	150
4,475 UNIFORM	145
4,486 SERVICE	47,769
4,490 MISC EX	624
4,496 MISC. M.	9,900
4,510 REAL ES	0
4,600 LEASED	19,927
5,110 MAINTEI	89,217
5,120 MAINTEI	8,057
5,130 ELECTRI	82,629
5,131 NATURA	33,205
5,133 WATER &	41,952
5,134 TRASH C	23,356
5,140 PROP/PL	33,808
5,160 GENERA	49,186
5,165 MAINTEI	19,368
5,210 DIETARY	530,962
5,220 DIETARY	36,938
5,248 FOOD PU	357,700

5,250 SUPPLIE	3,970
5,260 REPLACI	2,083
5,270 KITCHEN	16,594
5,295 MEAL IN	(246,767)
5,310 LAUNDR	76,474
5,340 LAUNDR	5,627
5,370 REPLACI	18,118
	0
5,390 SUPPLIE	7,946
5,410 HOUSEK	149,279
5,440 HOUSEK	10,260
5,480 SUPPLIE	91,309
5,490 SUPPLIE	178
6,020 RN WAG	639,676
6,030 DON WA	71,456
6,035 ADON W	59,703
6,040 RN PTO &	59,312
6,120 LPN WAG	512,852
6,140 LPN PTO	54,414
6,220 AIDES W	1,285,718
6,240 AIDES PT	95,616
6,245	
	12,536
	1,820
	0
6,270 REHAB V	64,228
6,275 REHAB F	5,185
6,290 NURSINC	71,496
6,295 NURSINC	128,026
6,390 REPLACI	16,247
6,490 OTHER	2,940

7,280 DRUG PU	450,775
7,281 DRUG PU	463,959
7,380 LABORA	19,926
7,390 X-RAY S	10,627
	21,192
7,510 ACTIVIT	75,499
7,540 ACTIVIT	8,784
7,590 ACTIVIT	4,023
7,620 PHYSICA	392,639
7,660 P.T. SUPE	1,526
7,710 SOCIAL S	42,699
7,720 SOCIAL S	2,970
7,730 SOCIAL S	745
7,740 OCCUPA	400,835
7,770 SPEECH '	47,686
7,820 BEAUTIC	16,180
	1,039
	0
8,120 INTERES	0
	43,735
8,130 DEPRECI	0
	0
9,510 INTERES	(341)
9,520 MISC NO	0
4,220	0
8,100	569,400
9,702	0
5,230	0
	<u>(618,975)</u>

Expenses Fixed Assets

