FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0007880

Facility Name: Country Health

Address: 2304 C R 3000 N (Number) Gifford (City) 61847 (Zip Code)

County: Champaign

Telephone Number: 217-568-7362 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1970

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Dave Underwood **Telephone Number:** (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) David M. Underwood
(Title) Sr. VP & CFO

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,622	16,015	3,413	31,050	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,622	16,015	3,413	31,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.58%

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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,413

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	254,110	23,025		277,135		277,135		277,135			1
2	Food Purchase		214,118		214,118		214,118		214,118			2
3	Housekeeping	114,624	28,073		142,697		142,697		142,697			3
4	Laundry	61,079	18,011		79,090		79,090		79,090			4
5	Heat and Other Utilities			197,109	197,109		197,109		197,109			5
6	Maintenance	77,426	67,340	57,427	202,193		202,193		202,193			6
7	Other (specify):*											7
8	TOTAL General Services	507,239	350,567	254,536	1,112,342		1,112,342		1,112,342			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,818,400	120,658	8,192	1,947,250		1,947,250		1,947,250			10
10a	Therapy		252,013	529,008	781,021	(297,297)	483,724		483,724			10a
11	Activities	68,185	3,862		72,047		72,047		72,047			11
12	Social Services	30,134		3,175	33,309		33,309		33,309			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,916,719	376,533	553,575	2,846,827	(297,297)	2,549,530		2,549,530			16
	C. General Administration											
17	Administrative	84,342			84,342		84,342		84,342			17
18	Directors Fees											18
19	Professional Services			173,909	173,909		173,909	(15,119)	158,790			19
20	Dues, Fees, Subscriptions & Promotions			88,260	88,260	(48,728)	39,532	(28,461)	11,071			20
21	Clerical & General Office Expenses	194,377	15,649	7,143	217,169		217,169		217,169			21
22	Employee Benefits & Payroll Taxes			595,820	595,820		595,820		595,820			22
23	Inservice Training & Education			5,022	5,022		5,022		5,022			23
24	Travel and Seminar			7,511	7,511		7,511	(5,512)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			148,198	148,198		148,198		148,198			26
27	Other (specify):*			24,054	24,054		24,054	(24,000)	54			27
28	TOTAL General Administration	278,719	15,649	1,049,917	1,344,285	(48,728)	1,295,557	(73,092)	1,222,465			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,702,677	742,749	1,858,028	5,303,454	(346,025)	4,957,429	(73,092)	4,884,337			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 Country Health #0007880 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			370,336	370,336		370,336		370,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			284,497	284,497		284,497	(22,145)	262,352			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,668	20,668		20,668		20,668			35
36	Other (specify):*											36
37	**TOTAL Ownership**			675,501	675,501		675,501	(22,145)	653,356			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					297,297	297,297		297,297			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					346,025	346,025		346,025			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,702,677	742,749	2,533,529	5,978,955		5,978,955	(95,237)	5,883,718			45

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(22,145)			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	(1,383)			17
18	Fines and Penalties				18
19	Entertainment	(5,512)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,119)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)			24
25	Fund Raising, Advertising and Promotional	(27,078)			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)**	$ (95,237)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (95,237)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS **Page 5A**

Country Health

ID# 0007880

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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		(1,383)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(15,119)	19	22
23				23
24		(24,000)	27	24
25		(27,078)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,580)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Health # 0007880 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,119)	0	0	0	0	0	0	0	0	0	0	(15,119)	19
20	Fees, Subscriptions & Promotions	(28,461)	0	0	0	0	0	0	0	0	0	0	(28,461)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,512)	0	0	0	0	0	0	0	0	0	0	(5,512)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	**TOTAL General Administration**	(73,092)	0	0	0	0	0	0	0	0	0	0	(73,092)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,092)	0	0	0	0	0	0	0	0	0	0	(73,092)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Country Health # 0007880 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,145)	0	0	0	0	0	0	0	0	0	0	(22,145)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,145)	0	0	0	0	0	0	0	0	0	0	(22,145)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,237)	0	0	0	0	0	0	0	0	0	0	(95,237)	45

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

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

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Attached								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [x]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	7	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	United Community		x	Mortgage			$	$ 7,333,220			$ 284,497	1
2												2
3	EIEC		x	Mortgage				763,862				3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 8,097,082			$ 284,497	9
	B. Non-Facility Related*											
10	Interest Income										(22,145)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (22,145)	14
15	TOTALS (line 9+line14)						$	$ 8,097,082			$ 262,352	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.)**

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011		11
2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Health COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0007880

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior brick Frame wood Number of Stories

C. Does the Operating Entity? [x] (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? [x] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 27,031	1
2					2
3	TOTALS			$ 27,031	3

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	89				$ 744,720	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976 Improvements			1976	10,703						9
10	1977 Improvements			1979	15,361						10
11	1978 Improvements			1977	25,766						11
12	1979 Improvements			1978	6,618						12
13	1980 Improvements			1980	30,846						13
14	1981 Improvements			1981	18,567						14
15	1982 Improvements			1982	4,662						15
16	1983 Improvements			1983	28,833						16
17	1984 Improvements			1984	6,700						17
18	1985 Improvements			1985	33,953						18
19	1986 Improvements			1986	23,775						19
20	1987 Improvements			1987	40,603						20
21	1988 Improvements			1988	163,565						21
22	1989 Improvements			1989	50,581						22
23	1990 Improvements			1990	111,695						23
24	1991 Improvements			1991	36,516						24
25	1992 Improvements			1992	26,816						25
26	1993 Improvements			1993	21,383						26
27	1994 Improvements			1994	12,384						27
28	1995 Improvements			1995	5,450						28
29	NURSE CALL SYSTEM			1996	6,349						29
30	DINNING ROOM EXPANSION			1996	10,109						30
31	Dinning Room Remodel			1997	6,121						31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					303,407		303,407			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 Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room Remodel	1998	$ 212,044	$		$	$	$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,891,513	$ 303,407		$ 303,407	$	$	70

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,891,513	$ 303,407		$ 303,407	$	$	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	Ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,017,721	$ 303,407		$ 303,407	$	$	34

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,017,721	$ 303,407		$ 303,407	$	$	1
2									2
3	Resident Room Remodel-- Flooring, paint	2005	696						3
4	Door Alarm	2005	9,840						4
5	Board Room Remodel -- Paint	2005	741						5
6	Activity Room Remodel -- Paint, Flooring	2005	5,359						6
7	Employee Breakroom Remodel -- Paint	2005	1,182						7
8	Chiller	2005	46,799						8
9	Lobby Remodel -- Paint, Flooring	2005	23,981						9
10	Water valves	2005	24,320						10
11	Roof	2005	6,056						11
12	Nurse Call Station	2005	640						12
13	A/C Units	2005	5,127						13
14	Exterior Rehab	2005	1,172						14
15	Parking Lot Resurface	2005	1,449						15
16	CCTV Monitor and Camera	2005	2,407						16
17	Safety Control --Boiler	2005	1,180						17
18	Landscaping	2005	683						18
19	Dining Room Painting	2005	2,375						19
20	Flooring	2005	1,419						20
21									21
22	Dining Room Painting	2006	4,228						22
23	Landscaping	2006	1,411						23
24	Sewage Grinder	2006	18,519						24
25	Sidewalk	2006	1,997						25
26	Fire Door	2006	1,401						26
27	Resident Room Remodel-- Flooring, paint	2006	6,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,187,553	$ 303,407		$ 303,407	$	$	34

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,187,553	$ 303,407		$ 303,407	$	$	1
2									2
3	1/2 hp Auto Door Opener	2007	750						3
4	Water Heater	2007	6517						4
5	Roof Repair	2007	851						5
6	Water Main	2007	1462						6
7	Fire System	2007	1662						7
8	Boiler	2007	1044						8
9	Breakers	2007	1393						9
10	Water Softener	2007	1382						10
11									11
12	HVAC Units	2008	3627						12
13	Mixing Valve	2008	8834						13
14	Circulator Pump	2008	2869						14
15									15
16	Water Heater	2009	2860						16
17	Fire Door	2009	4245						17
18									18
19	Water Main	2011	5000						19
20									20
21	Landscapping	2012	18565						21
22	Drywall - Paint & touch-up	2012	3716						22
23	HVAC Compressors	2012	7,500						23
24	Renovation - Contracted Total	2012	6,858,714						24
25	Renovation - Capitalized Interest	2012	673,048						25
26	Renovation - Additional Third Party Costs	2012							26
27	Asbestos	2012	444,405						27
28	Professional Fees	2012	776,516						28
29	Technology	2012	258,985						29
30	Other - Flooring, Drywall Window Treatments	2012	56,856						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,328,354	$ 303,407		$ 303,407	$	$	34

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,328,354	$ 303,407		$ 303,407	$	$	1
2									2
3	Kitchen Booster Heater	2013	2,781						3
4	Fire Alarm System Module	2013	3,111						4
5	Courtyard Landscaping	2013	2,697						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,336,943	$ 303,407		$ 303,407	$	$	34

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,324,682	$ 66,929	$ 66,929	$		$	71
72	Current Year Purchases	20,065						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,344,747	$ 66,929	$ 66,929	$		$	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		2008 van		$ 39,380	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 39,380	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,748,101	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 370,336	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 370,336	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 Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [x] 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

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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 20,668 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.

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 207,374	$		$ 207,374	1
2	Licensed Speech and Language Development Therapist		hrs			21,548			21,548	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			254,555	247		254,802	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				251,766		251,766	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					45,531			45,531	13
14	TOTAL			$		$ 529,008	$ 252,013		$ 781,021	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.

STATE OF ILLINOIS

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 1,814,759	$	1
2	Cash-Patient Deposits	14,812		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	803,816		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,295		6
7	Other Prepaid Expenses	17,546		7
8	Accounts Receivable (owners or related parties)	4,804		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,707,032	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	680,148		13
14	Buildings, at Historical Cost	11,265,403		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,372,070		16
17	Accumulated Depreciation (book methods)	(3,329,230)		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)**	$ 9,988,391	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,695,423	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 259,481	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,812		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	220,353		30
31	Accrued Taxes Payable (excluding real estate taxes)	591		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	22,916		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Assessment Tax	86,491		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 604,644	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,097,082		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)**	$ 8,097,082	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,701,726	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,993,697	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,695,423	$	48

*(See instructions.)

Facility Name & ID Number Country Health # 0007880 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,661,865	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,661,865	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	331,832	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)**	$ 331,832	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)**	$ 3,993,697	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,015,005	1
2	Discounts and Allowances for all Levels	(2,043,001)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,972,004	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,840,596	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,840,596	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	446,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,229	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 456,568	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,145	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,145	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		19,474	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,474	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,310,787	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,112,342	31
32	Health Care	2,846,827	32
33	General Administration	1,344,285	33
	B. Capital Expense		
34	Ownership	675,501	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,978,955	40
41	**Income before Income Taxes (line 30 minus line 40)****	331,832	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 331,832	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 Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,900	1,900	$ 57,150	$ 30.08	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	16,642	17,672	478,295	27.07	3
4	Licensed Practical Nurses	20,783	22,262	488,349	21.94	4
5	CNAs & Orderlies	57,281	61,357	737,191	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,337	3,889	57,415	14.76	8
9	Activity Director					9
10	Activity Assistants	5,750	5,923	68,185	11.51	10
11	Social Service Workers	1,966	2,575	30,134	11.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,257	24,799	254,110	10.25	15
16	Dishwashers					16
17	Maintenance Workers	5,688	6,005	77,426	12.89	17
18	Housekeepers	11,646	12,311	114,624	9.31	18
19	Laundry	5,861	6,401	61,079	9.54	19
20	Administrator	1,900	2,080	84,342	40.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,406	10,131	194,377	19.19	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)	165,417	177,305	$ 2,702,677 *	$ 15.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		13,200		36
37	Medical Records Consultant		1,260		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,340		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,175		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,975		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chris Kasper			$ 84,342
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,342

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 136,200
Sulaski & Webb	Audit	8,500
Professional Valuation	Appraisal	4,000
EIEC	LOC Fee	2,590
Principal	401 K Fees	1,600
Tellatin, Short & Hanson	Bank Appraisal	5,900
Legal adj to Zero		15,119
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 173,909

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,256
Unemployment Compensation Insurance	15,073
FICA Taxes	206,755
Employee Health Insurance	284,443
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	11,293
TOTAL (agree to Schedule V, line 22, col.8)	$ 595,820

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,267
Health Care Worker Background Check	
(Indicate # of checks performed)	1,520
Patient Background Checks	
	8,652
Dues & Subscriptions	8,448
License & Fees	1,219
Less: Public Relations Expense	(8,652)
Non-allowable advertising	(1,383)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,071

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	5,972
	104
Seminar Expense	1,435
	(5,512)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Amount of Expense Amortized Per Year								
					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 Country Health # 0007880 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **48,728**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,195**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? 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. $

(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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
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 Line #	Adjustment Amount				
1009	PETTY CASH	1,814,759						1,009	1,009	PETTY C	1,814,759
1010	CASH IN BANK							1,100	1,100	ACCTS R	803,816
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	803,816						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	51,295
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	51,295						1,310	1,310	SUPPLIES INVENTORY	
1220	OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY	
1300	FOOD INVENTORY							1,409	1,409	LAND	680,148
1310	SUPPLIES INVENTORY							1,450	1,450	FURNITU	1,372,070
1409	LAND	680,148						1,460			(1,045,075)
1450	FURNITURE & EQUIPMENT	1,372,070						1,475	1,475	CODE AI	#########
1460	ACCUM DEPR-FURN & EQU	-1,045,075						1,490	1,490	ACCUM I	(2,284,155)
1475	BUILDING & IMPROVEMEN	11,265,403						1,530	1,530	RESIDEN	14,812
1490	ACCUM DEPR-BUILDING	-2,284,155						1,550	1,550	LOAN FE	17,546
1530	RESIDENT FUNDS	14,812						1,551	1,551	LOAN FEES ADDED	
1550	LOAN FEES	17,546						1,850	1,850	INTERCC	4,804
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	(259,481)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	4,804						2,100	2,100	ACCRUE	(83,947)
2010	ACCOUNTS PAYABLE	-259,481						2,100	2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-83,947						2,110	2,110	ACCRUE	(136,406)
2110	ACCRUED VACATION PAY	-136,406						2,120	2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-591	-591
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYA	-22,916	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-86,491	
2350	REAL ESTATE TAX PAYAB	0	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-14,812	
2600	MORTGAGE PAYABLE	-8,097,082	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-3,661,865	
2970	PROFIT/LOSS FOR PERIOD	-331,832	
3007.1	PATIENT DAYS-PRIVATE	16,015	

2,125	2,125	FICA TA:	(591)
2,130	2,130	FEDERAL W/H TAX PAYABLI	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE RE:	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETI	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNISHMENT	
2,300	2,300	ACCRUE	(22,916)
2,320	2,320	IPA PAY]	(86,491)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DI	
2,512	2,512	DUE TO]	(14,812)
2,600	2,600	LASALLI	(8,097,082)
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DI	
2,720	2,720	RETAINI	(3,661,865)
		net incom	(331,832)
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	11,622					3,007
3007.3		PATIENT DAYS-MEDICARE	3,413					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 &	-5,999,843	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	-12,203	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	-446,339	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-1,840,596	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	2,043,001	0	0	0	0	3,411
3411	2	MEDICAID PART B DISCOUNT		0	0	0	0	3,420
3420	2	MEDICARE DISCOUNTS		0	0	0	0	3,500

3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0			3,520
3520		16	RENT INCOME	0		6	0	6	0			3,530
3530		13	BEAUTY SHOP	0		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	0		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-2,959		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	-10,229		0	0	0	0			4,110
3600		21	MISC INCOME	0		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	178,588	194,377	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	84,342	84,342	17	1	0	0			4,120
4115			VACATION & SICK - G&A	15,789		21	1	0	0			4,125
4120	4475		EMPLOYEE BENEFITS	11,293	595,820	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	15,649	15,649	21	2	0	0			4,275
4260			TELEPHONE	7,143	7,143	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	5,022	5,022	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	5,972	7,511	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	104		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	1,435		24	3	19	-5,512	***		4,289
4290			HELP WANTED ADVERTISI	1,267	88,260	20	3	0	0	-48,728		4,290
4291			PROMOTIONAL ADVERTIS	18,426		20	3	25	-18,426			4,291
4292			PUBLIC RELATIONS	8,652		20	3	25	-8,652			4,292
4300			LICENSES & FEES	49,947		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	8,448		20	3	17	-1,383			4,310
4320			CONTRIBUTIONS	0		27	3	20	0			4,320
4350			PROFESSIONAL FEES	37,709	173,909	19	3	22	-15,119			4,350
4355			MEDICAL DIRECTOR	13,200	13,200	9	3	0	0			4,355
4360			UTILIZATION REVIEW	0		10	3	0	0			4,362
4361			OTHER PHYSICIAN FEES			39	3	0	0			4,363

4362	MEDICAL RECORDS CONSI	1,260		10	3	0	0		4,364
4363	PHARMACIST FEES	5,340		10	3	0	0		4,370
4364	SOC SERV/ACT CONSULT	3,175	3,175	12	3	0	0		4,383
4370	TV RENTAL	8,279		35	3	5	0		4,390
4380	INCOME TAXES		24,054	27	3	26	0		4,400
4383	BACKGROUND CHECKS	1,520		20	3	26	0		4,401
4400	PAYROLL TAXES	213,073		22	3	0	0		4,410
4401	PAYROLL TAXES ADMINIS	8,755		22	3	0	0		4,420
4410	GROUP INSURANCE	284,443		22	3	0	0		4,430
4420	LIABILITY INSURANCE	148,198	148,198	26	3	0	0		4,435
4425	INSURANCE-OWNERS			22	3	21	0		4,436
4430	WORKMENS COMP INSURA	78,256		22	3	0	0		4,450
4450	CENTRAL OFFICE FEES	136,200		19	3	34	0	**	4,460
4460	BAD DEBTS	24,000		27	3	24	-24,000		4,461
4470	LOST ITEMS-RESIDENTS	54		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	12,389	20,668	35	3	16	0		4,490
5110	MAINTENANCE SALARIES	75,750	77,426	6	1	0	0		4,496
5120	MAINTENANCE SICK & VA	1,676		6	1	0	0		4,510
5130	ELECTRIC	163,483	197,109	5	3	0	0		4,600
5131	NATURAL GAS	19,306		5	3	0	0		5,110
5132	HEATING & DEISEL OIL			5	3	0	0		5,120
5133	WATER & SEWER	14,320		5	3	0	0		5,130
5134	TRASH COLLECTION	12,501	57,427	6	3	0	0		5,131
5140	PROPERTY PLANT REPLAC	8,734	67,340	6	2	0	0		5,133
5160	GENERAL REPAIR & MAIN	58,606		6	2	0	0		5,134
5165	MAINTENANCE CONTRAC	44,926		6	3	0	0		5,140
5210	DIETARY WAGES	239,143	254,110	1	1	0	0		5,160
5220	DIETARY SICK & VAC	14,967		1	1	0	0		5,165
5240	SALES TAX			2	3	13	0		5,210
5248	FOOD PURCHASES	220,313	214,118	2	2	0	0		5,220
5250	SUPPLIES-DISHWASHING	4,111	23,025	1	2	0	0		5,248

5260	DIETARY REPLACEMENT	10,048		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	8,866		1	2	0	0	5,260
5295	MEAL CREDIT	-6,195		2	2	0	0	5,270
5310	LAUNDRY WAGES	58,736	61,079	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,343		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	6,968	18,011	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	11,043		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	105,876	114,624	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	8,748		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	11,097	28,073	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	16,976		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,818,400	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	443,632		10	1	0	0	6,020
6030	DON WAGES	57,150		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	34,663		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	460,705		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	27,644		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC/	692,270		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	44,921		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	54,431		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,984		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0		7,280
6290	NURSING SUPPLIES	108,102	120,658	10	2	0	0		7,281
6295	NURSING SUPPLIES	284		10	2	0	0		7,380
6390	REPLACEMENT-NURSING	12,272		10	2	0	0		7,391
6490	NURSING OTHER	1,592	8,192	10	3	0	0		7,393
7280	DRUG PURCHASES	251,558	252,013	39	2	0	0	***	7,510
7281	DRUG PURCHASES-OTHER	208		39	2				7,540
7380	LABORATORY SERVICES	45,531	529,008	39	3	0	0		7,590
7410	HOME HEALTH SALARY			39	1	0	0		7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0		7,660
7450	HOME HEALTH EXPENSES			39	3	0	0		7,710
7510	ACTIVITES WAGES	63,943	68,185	11	1	0	0		7,720
7540	ACTIVITIES SICK & VAC	4,242		11	1	0	0		7,730
7590	ACTIVITIES SUPPLIES	3,862	3,862	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	254,555		39	3	0	0	***	7,890
7660	PT SUPPLIES	247		39	2	0	0		7,960
7710	SOCIAL SERVICE WAGES	27,959	30,134	12	1	0	0		8,120
7720	SOCIAL SERVICE SICK & V	2,175		12	1	0	0		8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0		8,130
7740	OT FEE	207,374		39	3	0	0	***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510
7770	SPEECH THERAPY FEE	21,548		39	3	0	0	***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0		9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0		
7820	BEAUTICIAN FEES	0	0	40	3	0	0		
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910	VOLUNTEER COORDINATOR			21	1	0	0		
7940	VOL COORD SICK & VAC			21	1	0	0		
7960	VOL COORD SUPPLIES	0		21	2	0	0		
8100	RENT	0	0	34	3	0	0		

8120	INTEREST EXPENSE	281,065	284,497	32	3	14	-22,145	
8130	DEPRECIATION	370,336	370,336	30	3	9	0	
8150	LOAN FEE AMORTIZATION	3,432		32	3	0	0	60,773
9510	INTEREST INCOME	-22,145		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	-19,474		0	0	0	0	
		5,937,336	5,978,955					
			41,619					
GRAND TOTALS		-331,832					-95,237	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	16,015	16,015
IPA	11,622	11,622
medicare	3,413	3,413
		31,050

IPA BEDHOLDS 0
PP BEDHOLDS 0
PP CONVERS 0

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FUND

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EBT

EBT

3,007 PATIENT 16,015

3,007	PATIENT	11,622
3,007	PATIENT	3,413
		0
3,010	BASIC CH	(5,999,843)
3,020	BASIC CH	0
3,030	BASIC CH	0
		0
		0
		0
		0
3,080	NURSING	(12,203)
3,081	NURSING	0
3,082	NURSING	0
3,083	NURSING	0
3,100	DRUGS-M	(446,339)
		0
3,110	PHYSICAL	(1,840,596)
		0
3,112	PHYSICAL	0
3,113	PHYSICAL	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTHE	0
3,411	MEDICAR	0
3,420	MEDICAR	1,984,382

3,520	RENT INC	0
3,530	BEAUTY S	0
		0
3,570	VENDING	0
3,590	EQUIPME	(2,959)
3,595	RESIDENT	(10,229)
3,600	MISC INC	0
4,110	G&A WAG	178,588
4,111	ADMINIST	84,342
4,115	G&A PTO	15,789
4,120	EMPLOYE	10,942
4,130	EMPLOYE	0
4,135	EMPLOYE	0
4,250	OFFICE SU	6,146
4,255	POSTAGE	1,435
4,260	TELEPHO	7,143
4,275	TRAININ(	5,022
		0
4,280	GENERAI	5,972
4,281	MEAL EX	104
4,285	EDUCATI	1,435
4,289	MEETING	0
4,290	HELP WA	1,267
4,291	PROMOTI	18,426
4,292	PUBLIC R	8,652
4,300	LICENSE	49,947
4,310	DUES & S	8,448
4,320	CONTRIB	0
4,350	PROFESSI	37,709
4,355	MEDICAL	13,200
		1,260
		5,340

4,364	SOCIAL S	3,175
4,370	TV RENT/	8,279
4,383	BACKGR(	1,520
4,390	OTHER T/	0
4,400	PAYROLL	213,073
4,401	PAYROLL	8,755
4,410	GROUP IN	284,443
4,420	LIABILIT'	148,198
4,430	WORKMA	76,365
4,435	W/C-FIRS'	406
4,436	DRUG TE:	1,485
4,450	MANAGE	136,200
4,460	BAD DEB'	24,000
4,461	BAD DEB'	58,619
4,470	LOST ITE:	54
4,475	UNIFORM	351
4,486	SERVICE	20,566
4,490	MISC EXP	31
4,496	MISC. M.I	8,068
4,510	REAL EST	0
4,600	LEASED E	12,389
5,110	MAINTEN	75,750
5,120	MAINTEN	1,676
5,130	ELECTRI(	163,483
5,131	NATURAL	19,306
5,133	WATER &	14,320
5,134	TRASH C(	12,501
5,140	PROP/PLA	8,734
5,160	GENERAL	58,606
5,165	MAINTEN	24,360
5,210	DIETARY	239,143
5,220	DIETARY	14,967
5,248	FOOD PU	220,282

5,250	SUPPLIES	4,111
5,260	REPLACE	10,048
5,270	KITCHEN	8,866
5,295	MEAL INC	(6,195)
5,310	LAUNDRY	58,736
5,340	LAUNDRY	2,343
5,370	REPLACE	6,968
		3,574
5,390	SUPPLIES	7,469
5,410	HOUSEKE	105,876
5,440	HOUSEKE	8,748
5,480	SUPPLIES	11,097
5,490	SUPPLIES	16,976
6,020	RN WAGE	443,632
6,030	DON WAC	57,150
6,035	ADON WA	0
6,040	RN PTO &	34,663
6,120	LPN WAG	460,705
6,140	LPN PTO	27,644
6,220	AIDES WA	692,270
6,240	AIDES PT	44,921
		0
		0
		0
6,270	REHAB W	54,431
6,275	REHAB PT	2,984
6,290	NURSING	108,102
6,295	NURSING	284
6,390	REPLACE	12,272
6,490	OTHER	1,592

7,280	DRUG PU	251,558
7,281	DRUG PU	208
7,380	LABORAT	23,331
7,390	X-RAY SE	22,200
		0
7,510	ACTIVITI	63,943
7,540	ACTIVITI	4,242
7,590	ACTIVITI	3,862
7,620	PHYSICA	254,555
7,660	P.T. SUPP	247
7,710	SOCIAL S	27,959
7,720	SOCIAL S	2,175
7,730	SOCIAL S	0
7,740	OCCUPAT	207,374
7,770	SPEECH T	21,548
7,820	BEAUTIC	0
		0
		0
8,120	INTEREST	281,065
		0
8,130	DEPRECI	370,336
		3,432
9,510	INTEREST	(22,145)
9,520	MISC NO	(19,474)
4,220		0
8,100		0
9,702		0
5,230		0
		(331,832)

Expenses Fixed Assets