

Facility Name & ID Number Heritage Health-Hoopeston

0052027 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	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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	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	17,465	7,730	1,550	26,745	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,465	7,730	1,550	26,745	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.70%

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)

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 Nov 2012

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 1,550

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Heritage Health-Hoopeston

0052027

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 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	213,168	12,648		225,816		225,816	225,816			1
2	Food Purchase		173,815		173,815		173,815	173,815			2
3	Housekeeping	102,237	20,712		122,949		122,949	122,949			3
4	Laundry		92,565		92,565		92,565	92,565			4
5	Heat and Other Utilities			81,150	81,150		81,150	81,150			5
6	Maintenance	67,261	38,532	46,675	152,468		152,468	152,468			6
7	Other (specify):*										7
8	TOTAL General Services	382,666	338,272	127,825	848,763		848,763	848,763			8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	1,290,080	65,683	593	1,356,356		1,356,356	1,356,356			10
10a	Therapy		97,994	246,746	344,740	(104,691)	240,049	240,049			10a
11	Activities	64,050	1,183		65,233		65,233	65,233			11
12	Social Services	42,998		1,157	44,155		44,155	44,155			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,397,128	164,860	260,496	1,822,484	(104,691)	1,717,793	1,717,793			16
	C. General Administration										
17	Administrative	76,442			76,442		76,442	76,442			17
18	Directors Fees										18
19	Professional Services			202,900	202,900		202,900	(1,012)	201,888		19
20	Dues, Fees, Subscriptions & Promotions			59,706	59,706	(41,063)	18,643	(10,047)	8,596		20
21	Clerical & General Office Expenses	120,462	14,860	10,829	146,151		146,151	146,151			21
22	Employee Benefits & Payroll Taxes			414,764	414,764		414,764	414,764			22
23	Inservice Training & Education			4,554	4,554		4,554	4,554			23
24	Travel and Seminar			5,075	5,075		5,075	(3,076)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,078	41,078		41,078	41,078			26
27	Other (specify):*			12,335	12,335		12,335	(12,000)	335		27
28	TOTAL General Administration	196,904	14,860	751,241	963,005	(41,063)	921,942	(26,135)	895,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,976,698	517,992	1,139,562	3,634,252	(145,754)	3,488,498	(26,135)	3,462,363		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-Hoopeston

#0052027

Report Period Beginning:

01/01/13

Ending:

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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			213,905	213,905		213,905		213,905			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			227,956	227,956		227,956		227,956			32
33	Real Estate Taxes							(1,821)	(1,821)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,633	10,633		10,633		10,633			35
36	Other (specify):*											36
37	TOTAL Ownership			452,494	452,494		452,494	(1,821)	450,673			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					104,691	104,691		104,691			39
40	Barber and Beauty Shops			18,434	18,434		18,434		18,434			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			18,434	18,434	145,754	164,188		164,188			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,976,698	517,992	1,610,490	4,105,180		4,105,180	(27,956)	4,077,224			45

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

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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				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	(1,821)			15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(35)			17
18	Fines and Penalties				18
19	Entertainment	(3,076)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,012)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)			24
25	Fund Raising, Advertising and Promotional	(10,012)			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)	\$ (27,956)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (27,956)		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-Hoopeston

ID# 0052027

Report Period Beginning: 01/01/13

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		(35)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,012)	19	22
23				23
24		(12,000)	27	24
25		(10,012)	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		(23,059)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Hoopeston# 0052027

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	(1,012)	0	0	0	0	0	0	0	0	0	0	(1,012)	19
20	Fees, Subscriptions & Promotions	(10,047)	0	0	0	0	0	0	0	0	0	0	(10,047)	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	(3,076)	0	0	0	0	0	0	0	0	0	0	(3,076)	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):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	TOTAL General Administration	(26,135)	0	0	0	0	0	0	0	0	0	0	(26,135)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,135)	0	0	0	0	0	0	0	0	0	0	(26,135)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Hoopeston

0052027

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(1,821)	0	0	0	0	0	0	0	0	0	0	(1,821)	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	(1,821)	0	0	0	0	0	0	0	0	0	0	(1,821)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(27,956)	0	0	0	0	0	0	0	0	0	0	(27,956)	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

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.

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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							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	\$ *	39

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

Facility Name & ID Number

Heritage Health-Hoopeston

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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

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	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

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

Facility Name & ID Number

Heritage Health-Hoopeston

0052027

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		7	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	USDA		x	Construction of new facility			\$	\$ 5,882,623			\$	227,956						
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$ 5,882,623			\$	227,956						
B. Non-Facility Related*																		
10	Interest Income																	
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$							
15	TOTALS (line 9+line14)						\$	\$ 5,882,623			\$	227,956						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 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	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				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 Heritage Health-Hoopeston COUNTY Vermillion

FACILITY IDPH LICENSE NUMBER 0052027

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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,304 B. General Construction Type: Exterior Brick Frame Wood Number of Stories _____

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>200,000</u>	1
2					2
3	TOTALS			\$ <u>200,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	75		2012	\$ 6,101,158	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9								
10	Remodel Therapy Room - Labor & Materials		2013	28,083				
11	Utility Shed		2013	2,948				
12	Visionlink Wireless Installation		2013	35,612				
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	Book Depreciation				157,102		157,102	
35								
36								

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,167,801	\$ 157,102		\$ 157,102	\$	\$	70

**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	\$ 396,539	\$ 56,803	\$ 56,803	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 396,539	\$ 56,803	\$ 56,803	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,764,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 213,905	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 213,905	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 10,633 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 Heritage Health-Hoopeston # 0052027 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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 128,579	\$		\$ 128,579	1
2	Licensed Speech and Language Development Therapist		hrs			1,588			1,588	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			109,830	52		109,882	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				97,942		97,942	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,749			6,749	13
14	TOTAL			\$		\$ 246,746	\$ 97,994		\$ 344,740	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-Hoopeston# 0052027Report 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 402,856	\$	1
2	Cash-Patient Deposits	14,217		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	858,044		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,180		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	8,721		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,317,018	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	232,421		13
14	Buildings, at Historical Cost	6,167,802		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	396,539		16
17	Accumulated Depreciation (book methods)	(265,229)		17
18	Deferred Charges	231,751		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)	\$ 6,763,284	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,080,302	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 192,066	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,217		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,229		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	77,908		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 288,420	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,882,623		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)	\$ 5,882,623	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,171,043	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,909,259	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,080,302	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,975,504	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,975,504	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(66,245)	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)	\$ (66,245)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,909,259	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,864,988	1
2	Discounts and Allowances for all Levels	(844,624)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,020,364	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	862,415	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 862,415	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	10	12
13	Barber and Beauty Care	18,010	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	135,789	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,172	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 154,981	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,175	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,175	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,038,935	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	848,763	31
32	Health Care	1,822,484	32
33	General Administration	963,005	33
B. Capital Expense			
34	Ownership	452,494	34
C. Ancillary Expense			
35	Special Cost Centers	18,434	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)*	\$ 4,105,180	40
41	Income before Income Taxes (line 30 minus line 40)**	(66,245)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (66,245)	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-Hoopeston

0052027

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,968	2,024	\$ 59,604	\$ 29.45	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,585	7,674	212,459	27.69	3
4	Licensed Practical Nurses	12,618	12,864	279,432	21.72	4
5	CNAs & Orderlies	57,994	59,624	693,856	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,638	1,684	44,729	26.56	8
9	Activity Director					9
10	Activity Assistants	5,089	5,343	64,050	11.99	10
11	Social Service Workers	1,982	2,024	42,998	21.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,618	16,959	213,168	12.57	15
16	Dishwashers					16
17	Maintenance Workers	3,820	3,885	67,261	17.31	17
18	Housekeepers	9,239	9,397	102,237	10.88	18
19	Laundry			0		19
20	Administrator	1,900	2,080	76,442	36.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,399	5,635	120,462	21.38	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)	125,850	129,193	\$ 1,976,698 *	\$ 15.30	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	12,000		36
37	Medical Records Consultant	236		37
38	Nurse Consultant			38
39	Pharmacist Consultant	0		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	1,157		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 13,393		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Beth Totheroh			\$ 76,442	Workers' Compensation Insurance	\$ 35,411	IDPH License Fee	\$	
				Unemployment Compensation Insurance	34,866	Advertising: Employee Recruitment	226	
				FICA Taxes	151,217	Health Care Worker Background Check (Indicate # of checks performed _____)	1,215	
				Employee Health Insurance	183,649	Patient Background Checks		
				Employee Meals			7,060	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,020	
				Other Benefits	9,621	License & Fees	4,170	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,442			Less: Public Relations Expense	(7,060)	
B. Administrative - Other						Non-allowable advertising	(35)	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 8,596	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 414,764	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgt		\$ 201,888			\$	Out-of-State Travel	\$
							In-State Travel	
								3,986
								162
							Seminar Expense	927
								(3,076)
Legal adj to Zero			1,012				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 202,900	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Heritage Health-Hoopeston

0052027

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? No
If YES, give association name and amount. _____
- (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 Yrs
- (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. \$ 41,063
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. \$ 6,711
- (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? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
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: Russ Leigh
- (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 Adjustment Line #	Amount
1009	PETTY CASH	402,856				1,009	1,009 PETTY C 402,856
1010	CASH IN BANK					1,100	1,100 ACCTS R 858,044
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	858,044				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 33,180
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	33,180				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 232,421
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 396,539
1409	LAND	232,421				1,460	(69,610)
1450	FURNITURE & EQUIPMENT	396,539				1,475	1,475 CODE AI 6,167,802
1460	ACCUM DEPR-FURN & EQU	-69,610				1,490	1,490 ACCUM] (195,619)
1475	BUILDING & IMPROVEMEN	6,167,802				1,530	1,530 RESIDEN 14,217
1490	ACCUM DEPR-BUILDING	-195,619				1,550	1,550 LOAN FE 231,751
1530	RESIDENT FUNDS	14,217				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	231,751				1,850	1,850 INTERCC 8,721
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (192,066)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	8,721				2,100	2,100 ACCRUE 0
2010	ACCOUNTS PAYABLE	-192,066				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	0				2,110	2,110 ACCRUE 0
2110	ACCRUED VACATION PAY	0				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	0
2125	FICA TAX PAYABLE	0	0	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE	
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 - CAFETI	
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	(4,229)
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(77,908)
2300	ACCRUED INTEREST PAYA	-4,229		2,350	2,350 REAL ES	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-77,908		2,400	2,400 CURRENT PORTION OF LT DE	
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(14,217)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(5,882,623)
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 DE	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	(1,975,504)
2460	INCOME TAXES PAYABLE				net incom	66,245
2512	DUE TO RESIDENTS	-14,217				
2600	MORTGAGE PAYABLE	-5,882,623				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-1,975,504				
2970	PROFIT/LOSS FOR PERIOD	66,245				
3007.1	PATIENT DAYS-PRIVATE	7,730				3,007

3007.2	PATIENT DAYS-IPA	17,465						3,007
3007.3	PATIENT DAYS-MEDICARE	1,550						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-3,829,863	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	-31,894	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	-135,789	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-862,415	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	844,624	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	-18,010		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-10		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	-3,231		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-948		0	0	0	0		4,110
3600	21 MISC INCOME	-224		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	102,173	120,462	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	76,442	76,442	17	1	0	0		4,120
4115	VACATION & SICK - G&A	18,289		21	1	0	0		4,125
4120 4475	EMPLOYEE BENEFITS	9,621	414,764	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	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	14,860	14,860	21	2	0	0		4,275
4260	TELEPHONE	10,829	10,829	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	4,554	4,554	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	3,986	5,075	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	162		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	927		24	3	19	-3,076 ***		4,289
4290	HELP WANTED ADVERTISING	226	59,706	20	3	0	0 -41,063		4,290
4291	PROMOTIONAL ADVERTISING	2,952		20	3	25	-2,952		4,291
4292	PUBLIC RELATIONS	7,060		20	3	25	-7,060		4,292
4300	LICENSES & FEES	45,233		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	3,020		20	3	17	-35		4,310
4320	CONTRIBUTIONS	335		27	3	20	0		4,320
4350	PROFESSIONAL FEES	1,012	202,900	19	3	22	-1,012		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	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	236		10	3	0	0	4,364
4363	PHARMACIST FEES	0		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	1,157	1,157	12	3	0	0	4,383
4370	TV RENTAL	10,069		35	3	5	0	4,390
4380	INCOME TAXES		12,335	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,215		20	3	26	0	4,401
4400	PAYROLL TAXES	178,148		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	7,935		22	3	0	0	4,420
4410	GROUP INSURANCE	183,649		22	3	0	0	4,430
4420	LIABILITY INSURANCE	41,078	41,078	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	35,411		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	201,888		19	3	34	0 **	4,460
4460	BAD DEBTS	12,000		27	3	24	-12,000	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	-1,821	4,486
4600	LEASED EQUIPMENT	564	10,633	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	63,413	67,261	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	3,848		6	1	0	0	4,510
5130	ELECTRIC	65,435	81,150	5	3	0	0	4,600
5131	NATURAL GAS	6,712		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	9,003		5	3	0	0	5,130
5134	TRASH COLLECTION	8,732	46,675	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	8,911	38,532	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	29,621		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	37,943		6	3	0	0	5,140
5210	DIETARY WAGES	200,071	213,168	1	1	0	0	5,160
5220	DIETARY SICK & VAC	13,097		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	180,526	173,815	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,193	12,648	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	2,489		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,966		1	2	0	0	5,260
5295	MEAL CREDIT	-6,711		2	2	0	0	5,270
5310	LAUNDRY WAGES	0	0	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	0		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	1,887	92,565	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	90,678		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	96,141	102,237	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	6,096		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	19,932	20,712	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	780		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,290,080	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	202,152		10	1	0	0	6,020
6030	DON WAGES	59,604		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	10,307		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	266,389		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	13,043		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	658,873		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	34,983		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	41,406		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,323		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	4,161	65,683	10	2	0	0	7,281
6295	NURSING SUPPLIES	59,996		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	1,526		10	2	0	0	7,391
6490	NURSING OTHER	357	593	10	3	0	0	7,393
7280	DRUG PURCHASES	72,040	97,994	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	25,902		39	2			7,540
7380	LABORATORY SERVICES	6,749	246,746	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	59,845	64,050	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,205		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	1,183	1,183	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	109,830		39	3	0	0 ***	7,890
7660	PT SUPPLIES	52		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	43,971	42,998	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	-973		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	128,579		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	1,588		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	16,657	18,434	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	1,777	1,777	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	219,895	227,956	32	3	14	0	
8130	DEPRECIATION	213,905	213,905	30	3	9	0	
8150	LOAN FEE AMORTIZATION	8,061		32	3	0	0	60,773
9510	INTEREST INCOME	0		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	-1,175		0	0	0	0	
		4,104,005	4,106,957					
			2,952					

GRAND TOTALS 66,245 -27,956
(NET INCOME)

0
FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 75

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	7,730	7,730
IPA	17,465	17,465
medicare	1,550	1,550
		26,745
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT	17,465
3,007 PATIENT	1,550
	0

3,010 BASIC CH	(3,829,863)
3,020 BASIC CH	0
3,030 BASIC CH	0
	0
	0
	0
	0

3,080 NURSING	(31,894)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(135,789)
	0

3,110 PHYSICAL	(862,415)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

3,140 LABORATORY INCOME	0
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3,152 ST/OT TH	0
3,153 ST/OT TH	0

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHE	0
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3,411 MEDICAR	0
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3,420 MEDICAR	811,464
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3,520 RENT INC	0
3,530 BEAUTY :	(18,010)
	(10)
3,570 VENDING	0
3,590 EQUIPME	(3,231)
3,595 RESIDENT	(948)
3,600 MISC INC	(224)
4,110 G&A WAC	102,173
4,111 ADMINIS'	76,442
4,115 G&A PTO	18,289
4,120 EMPLOYE	9,644
4,130 EMPLOYE	0
4,135 EMPLOYE	0
4,250 OFFICE SU	5,206
4,255 POSTAGE	990
4,260 TELEPHO	10,829
4,275 TRAINING	4,554
	0
4,280 GENERAL	3,986
4,281 MEAL EX	162
4,285 EDUCATI	911
4,289 MEETING	16
4,290 HELP WA	226
4,291 PROMOTI	2,952
4,292 PUBLIC R	7,060
4,300 LICENSE	45,233
4,310 DUES & S	3,020
4,320 CONTRIB	335
4,350 PROFESSI	1,012
4,355 MEDICAL	12,000
	236
	0

4,364 SOCIAL S	1,157
4,370 TV RENTL	10,069
4,383 BACKGR	1,215
4,390 OTHER T	0
4,400 PAYROLL	178,148
4,401 PAYROLL	7,935
4,410 GROUP IN	183,649
4,420 LIABILIT	41,078
4,430 WORKMA	31,515
4,435 W/C-FIRS	2,325
4,436 DRUG TE	1,571
4,450 MANAGE	201,888
4,460 BAD DEB'	12,000
4,461 BAD DEB'	33,160
4,470 LOST ITE	0
4,475 UNIFORM	(23)
4,486 SERVICE	15,215
4,490 MISC EXP	1,242
4,496 MISC. M.I	8,664
4,510 REAL EST	0
4,600 LEASED F	564
5,110 MAINTEN	63,413
5,120 MAINTEN	3,848
5,130 ELECTRIC	65,435
5,131 NATURAL	6,712
5,133 WATER &	9,003
5,134 TRASH CO	8,732
5,140 PROP/PLA	8,911
5,160 GENERAL	29,621
5,165 MAINTEN	22,728
5,210 DIETARY	200,071
5,220 DIETARY	13,097
5,248 FOOD PUI	179,284

5,250 SUPPLIES	2,193
5,260 REPLACE	2,489
5,270 KITCHEN	7,966
5,295 MEAL INC	(6,711)
5,310 LAUNDRY	0
5,340 LAUNDRY	0
5,370 REPLACE	1,887
	90,472
5,390 SUPPLIES	206
5,410 HOUSEKE	96,141
5,440 HOUSEKE	6,096
5,480 SUPPLIES	19,932
5,490 SUPPLIES	780
6,020 RN WAGE	202,152
6,030 DON WAG	59,604
6,035 ADON WA	0
6,040 RN PTO &	10,307
6,120 LPN WAG	266,389
6,140 LPN PTO	13,043
6,220 AIDES WA	658,873
6,240 AIDES PT	34,983
	0
	0
	0
6,270 REHAB W	41,406
6,275 REHAB P	3,323
6,290 NURSING	4,161
6,295 NURSING	59,996
6,390 REPLACE	1,526
6,490 OTHER	357

7,280 DRUG PU	72,040
7,281 DRUG PU	25,902
7,380 LABORAT	3,803
7,390 X-RAY SE	2,946
	0
7,510 ACTIVITI	59,845
7,540 ACTIVITI	4,205
7,590 ACTIVITI	1,183
7,620 PHYSICAL	109,830
7,660 P.T. SUPP	52
7,710 SOCIAL S	43,971
7,720 SOCIAL S	(973)
7,730 SOCIAL S	0
7,740 OCCUPAT	128,579
7,770 SPEECH T	1,588
7,820 BEAUTIC	16,657
	1,777
	0
8,120 INTEREST	219,895
	0
8,130 DEPRECL	213,905
	8,061
9,510 INTEREST	0
9,520 MISC NOI	(1,175)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>66,245</u>

Expenses Fixed Assets

