

Facility Name & ID Number Henderson County Ret Center

0035246 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	5,304	7,007	1,387	13,698	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,304	7,007	1,387	13,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.55%

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)

n/a

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 06/28/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/16/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 60 and days of care provided 1,387

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Henderson County Ret Center

0035246

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	144,618	11,331	3,456	159,405		159,405		159,405		1
2	Food Purchase		101,163		101,163		101,163	(10,904)	90,259		2
3	Housekeeping	41,540	7,517		49,057		49,057		49,057		3
4	Laundry	22,040	4,234	193	26,467		26,467		26,467		4
5	Heat and Other Utilities			63,599	63,599		63,599		63,599		5
6	Maintenance	54,394	5,805	36,537	96,736		96,736	(10,000)	86,736		6
7	Other (specify):*										7
8	TOTAL General Services	262,592	130,050	103,785	496,427		496,427	(20,904)	475,523		8
	B. Health Care and Programs										
9	Medical Director			6,563	6,563		6,563		6,563		9
10	Nursing and Medical Records	758,544	82,594	3,222	844,360		844,360		844,360		10
10a	Therapy	12,443	540	166,549	179,532		179,532		179,532		10a
11	Activities	34,808	5,172	1,475	41,455		41,455		41,455		11
12	Social Services	17,824	308	1,475	19,607		19,607		19,607		12
13	CNA Training			415	415		415		415		13
14	Program Transportation	961	8,181		9,142		9,142		9,142		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	824,580	96,795	179,699	1,101,074		1,101,074		1,101,074		16
	C. General Administration										
17	Administrative	66,380			66,380		66,380		66,380		17
18	Directors Fees										18
19	Professional Services			47,186	47,186		47,186		47,186		19
20	Dues, Fees, Subscriptions & Promotions			19,982	19,982		19,982	(6,779)	13,203		20
21	Clerical & General Office Expenses	40,849	9,021	18,504	68,374		68,374	(2,500)	65,874		21
22	Employee Benefits & Payroll Taxes			187,349	187,349		187,349		187,349		22
23	Inservice Training & Education			3,356	3,356	(310)	3,046		3,046		23
24	Travel and Seminar			6,359	6,359	310	6,669		6,669		24
25	Other Admin. Staff Transportation		909		909		909		909		25
26	Insurance-Prop.Liab.Malpractice			42,015	42,015		42,015		42,015		26
27	Other (specify):*			3,752	3,752		3,752		3,752		27
28	TOTAL General Administration	107,229	9,930	328,503	445,662		445,662	(9,279)	436,383		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,194,401	236,775	611,987	2,043,163		2,043,163	(30,183)	2,012,980		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.

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#0035246

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			131,189	131,189		131,189	(12,065)	119,124			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,147	37,147		37,147	(11,352)	25,795			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,947	1,947		1,947		1,947			35
36	Other (specify):*											36
37	TOTAL Ownership			170,283	170,283		170,283	(23,417)	146,866			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,350		38,350		38,350		38,350			39
40	Barber and Beauty Shops		19	4,726	4,745		4,745		4,745			40
41	Coffee and Gift Shops		5,054		5,054		5,054		5,054			41
42	Provider Participation Fee		107,729		107,729		107,729		107,729			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		151,152	4,726	155,878		155,878		155,878			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,194,401	387,927	786,996	2,369,324		2,369,324	(53,600)	2,315,724			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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0035246

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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	(9,388)	2		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	(69)	30		9
10	Interest and Other Investment Income	(11,352)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,516)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,779)	20		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	(24,496)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (53,600)		\$	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))	\$ (53,600)		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

Henderson County Ret Center

ID# 0035246

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lease Buy-out (Deprec Cost)	\$ (11,996)	30	1
2	Allocation of Wages to SLF-Clerical	(2,500)	21	2
3	Allocation of Wages to SLF-Maintenance	(10,000)	6	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
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		(24,496)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,904)	0	0	0	0	0	0	0	0	0	0	(10,904)	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	(10,000)	0	0	0	0	0	0	0	0	0	0	(10,000)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,904)	0	0	0	0	0	0	0	0	0	0	(20,904)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,779)	0	0	0	0	0	0	0	0	0	0	(6,779)	20
21	Clerical & General Office Expenses	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(9,279)	0	0	0	0	0	0	0	0	0	0	(9,279)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,183)	0	0	0	0	0	0	0	0	0	0	(30,183)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/14 Ending:

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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	(12,065)	0	0	0	0	0	0	0	0	0	0	(12,065)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,352)	0	0	0	0	0	0	0	0	0	0	(11,352)	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	(23,417)	0	0	0	0	0	0	0	0	0	0	(23,417)	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)	(53,600)	0	0	0	0	0	0	0	0	0	0	(53,600)	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		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)	
		Item							
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 Henderson County Ret Center

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Report Period Beginning:

01/01/14

Ending:

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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

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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									\$		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 Henderson County Ret Center

0035246

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1	Security Savings		X	Mortgage	\$10,306.88	10/22/08	\$ 849,849	\$ 630,172	10/22/38	5.8750	\$ 37,147	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$10,306.88		\$ 849,849	\$ 630,172			\$ 37,147	9				
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 849,849	\$ 630,172			\$ 37,147	15				

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

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

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

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

B. Real Estate Taxes

		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 2013 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 2014 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:	2009 _____	8	FOR BHF USE ONLY		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Henderson County Ret Center COUNTY Henderson

FACILITY IDPH LICENSE NUMBER 0035246

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 2013 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 2013.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Henderson County Ret Center

0035246 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,636 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories 1

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

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

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

Rental House, Non-Healthcare Related
Supportive Living, 20 beds

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	<u>Care Related</u>	<u>217,600</u>	<u>1988</u>	<u>\$ 15,000</u>	1
2					2
3	TOTALS	217,600		\$ 15,000	3

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		1989	1988	\$ 1,260,000	\$ 42,031	30	\$ 42,000	\$ (31)	\$ 1,074,361	4
5	6		2000	2000	530,989	13,301	40	13,275	(26)	190,925	5
6											6
7											7
8											8
	Improvement Type**										
9		PARKING LOT/LANDSCAPING	1989		25,102		20			25,102	9
10		LANDSCAPING	1990		937		20			937	10
11		LAND IMPROVEMENT	1995		1,839	92	20	92		1,824	11
12		BRICK SIGN	1996		12,915	620	20	646	26	11,881	12
13		LAND IMPROVEMENT	1992		2,003		20			2,003	13
14		LIGHTNING RODS	1998		3,600		15			3,600	14
15		NEW SOFFITS	1998		26,138		15			26,138	15
16		PHONE SYSTEM	1998		6,738		15			6,738	16
17		SIDE WALKS	1998		4,500	226	20	225	(1)	3,653	17
18		ALARM SYSTEM	1998		8,266		10			8,266	18
19		LAUNDRY/GARAGE BLDG	1999		50,330	1,968	15	1,957	(11)	50,330	19
20		STORAGE BLDG	1999		8,911	348	15	347	(1)	8,911	20
21		NEW ROOF	1999		16,311	911	15	906	(5)	16,311	21
22		LANDSCAPING	2000		1,706	85	20	85		1,208	22
23		FURNICE	2001		2,848		10			2,848	23
24		NEW EXIT	2001		1,645	110	15	110		1,516	24
25		LANDSCAPING	2002		954		10			954	25
26		GARAGE/STORAGE BUILDING	2002		12,800	858	15	853	(5)	10,655	26
27		ROOFING/SHINGLES	2003		17,838	1,192	15	1,189	(3)	13,667	27
28		Walk-in Freezer	2007		20,883	1,044	20	1,044		7,396	28
29		Window Tinting	2007		2,985	150	20	149	(1)	1,074	29
30		Door Closures	2007		4,345	434	10	434		3,114	30
31		Window Tinting	2008		1,164	58	20	58		398	31
32		Generator	2009		101,961	5,098	20	5,098		28,464	32
33		Fire Sprinkler	2010		17,425	1,162	15	1,162		5,228	33
34		Sprinkler Heads	2011		17,425	1,162	15	1,162		4,356	34
35		Parking Lot/Driveway	2011		30,280	2,030	15	2,019	(11)	7,443	35
36		400 Hall-Painting Labor	2012		11,822	590	20	590		1,380	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room Paint	2012	\$ 5,415	\$ 271	20	\$ 271	\$	\$ 564	37
38	Dining Room Flooring	2012	18,677	934	20	934		1,946	38
39	400 Hall-new Handrails, Kickplates, Wall Coverings	2012	11,842	593	20	593		1,385	39
40	Door Alarms	2013	3,272	164	20	164		218	40
41	100 Hall-Flooring	2014	27,954	116	20	116		116	41
42	100 Hall-Painting Labor	2014	12,011	50	20	50		50	42
43	100 Hall-Construction Labor	2014	20,838	87	20	87		87	43
44	100 Hall-Wall Coverings	2014	8,363	35	20	35		35	44
45	100 Hall-Wall Plates	2014	1,724	7	20	7		7	45
46	100 Hall-Trim	2014	1,496	6	20	6		6	46
47	100 Hall-Building Materials	2014	10,572	44	20	44		44	47
48	100 Hall-Doors	2014	2,116	18	10	18		18	48
49	100 Hall-Shutters	2014	1,910	16	10	16		16	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)		\$ 2,330,850	\$ 75,811		\$ 75,742	\$ (69)	\$ 1,525,173	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	\$ 275,329	\$ 34,584	\$ 34,584	\$	9	\$ 138,327	71
72	Current Year Purchases	68,064	2,638	2,638		8	2,638	72
73	Fully Depreciated Assets	600,473				9	600,473	73
74								74
75	TOTALS	\$ 943,866	\$ 37,222	\$ 37,222	\$		\$ 741,438	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	Patient Transport	07 Dodge Caravan	2007	\$ 17,725	\$	\$	\$	5	\$ 17,725	76
77	Patient Transport	06 Ford e450	2008	35,095				5	35,095	77
78	Maintenance and Snow Rem	1995 Ford F250	2011	9,000	1,800	1,800		5	6,750	78
79	See List	See List	See List	47,183	4,360	4,360	1	5	8,002	79
80	TOTALS			\$ 109,003	\$ 6,160	\$ 6,160	\$ 1		\$ 67,572	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,398,719	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,193	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,124	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (69)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,334,183	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	Rental Property	\$ 68,955	\$ 2,344	\$ 16,799	86
87	Rental Property	4,597	156	1,068	87
88	Rental Property	13,703	465	581	88
89	Supportive Living	1,752,243	53,260	274,873	89
90					90
91	TOTALS	\$ 1,839,498	\$ 56,225	\$ 293,321	91

G. Construction-in-Progress

	Description	Cost	
92	Roof Repair	\$ (40,870)	92
93	Blue Prints-Renovation	33,500	93
94	Blue Prints-Assisted Living	1,181	94
95		\$ (6,190)	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 Henderson County Ret Center

0035246

Report Period Beginning: 01/01/14

Ending: 12/31/14

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 1,947 Description: Oxygen (\$347.23), Copier Rent (\$1,599.50),

(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 Henderson County Ret Center # 0035246 Report Period Beginning: 01/01/14 Ending: 12/31/14
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 checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	870	\$ 56,857	\$	870	\$ 56,857	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		49	4,131		49	4,131	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a-3	hrs		1,378	96,328		1,378	96,328	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-2	# of prescrpts				38,334		38,334	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	2,297	\$ 157,316	\$ 38,334	2,297	\$ 195,650	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 Henderson County Ret Center

0035246

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	\$ 302,108	\$ 374,933	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	327,886	372,822	3
4	Supply Inventory (priced at <u>FIFO</u>)	25,699	30,976	4
5	Short-Term Investments	510,715	510,715	5
6	Prepaid Insurance	10,930	26,024	6
7	Other Prepaid Expenses	11,205	14,710	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,188,543	\$ 1,330,180	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500	22,500	13
14	Buildings, at Historical Cost	2,680,513	4,356,445	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,167,187	1,243,499	16
17	Accumulated Depreciation (book methods)	(2,613,392)	(2,888,265)	17
18	Deferred Charges		(28,620)	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): <u>CIP</u>	(6,189)	(6,189)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,250,619	\$ 2,699,370	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,439,162	\$ 4,029,550	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 80,514	\$ 85,734	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,065	96,234	30
31	Accrued Taxes Payable (excluding real estate taxes)	294	298	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,345	32
33	Accrued Interest Payable	2,462	5,440	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>payroll withholdings</u>	2,256	2,256	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 166,591	\$ 191,307	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	630,172	1,902,293	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)	\$ 630,172	\$ 1,902,293	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 796,763	\$ 2,093,600	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,642,399	\$ 1,935,950	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,439,162	\$ 4,029,550	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,745,566	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,745,566	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	90,069	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) Rental Division	(4,363)	15
16	Other (describe) Supportive Living Division	104,678	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 190,384	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)	\$ 1,935,950	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	\$ 2,019,782	1	
2	Discounts and Allowances for all Levels	(21,073)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,998,709	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	291,078	6	
7	Oxygen	1,333	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 292,411	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	5,005	12	
13	Barber and Beauty Care	4,761	13	
14	Non-Patient Meals	9,388	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	53,920	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	1,809	19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry	720	22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 75,603	23	
D. Non-Operating Revenue				
24	Contributions	48,386	24	
25	Interest and Other Investment Income***	11,352	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59,738	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>See List Attached</u>	32,932	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,932	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,459,393	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	496,427	31	
32	Health Care	1,101,074	32	
33	General Administration	445,662	33	
B. Capital Expense				
34	Ownership	170,283	34	
C. Ancillary Expense				
35	Special Cost Centers	48,149	35	
36	Provider Participation Fee	107,729	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,369,324	40	
41	Income before Income Taxes (line 30 minus line 40)**	90,069	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 90,069	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 694,667	44
45	Private Pay - Net Inpatient Revenue	1,058,305	45
46	Medicare - Net Inpatient Revenue	230,363	46
47	Other-(specify) <u>Private Ancillary</u>	15,374	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,998,709	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Henderson County Ret Center

0035246

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,825	2,049	\$ 55,344	\$ 27.01	1
2	Assistant Director of Nursing	1,839	2,086	45,683	21.90	2
3	Registered Nurses	5,576	6,397	134,381	21.01	3
4	Licensed Practical Nurses	8,627	9,705	168,529	17.37	4
5	CNAs & Orderlies	28,259	30,300	321,953	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,055	1,201	12,443	10.36	8
9	Activity Director	1,961	2,086	25,165	12.06	9
10	Activity Assistants	1,100	1,133	9,643	8.51	10
11	Social Service Workers	1,244	1,422	17,824	12.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,481	1,856	27,651	14.90	14
15	Cook Helpers/Assistants	4,997	5,629	51,207	9.10	15
16	Dishwashers	6,721	7,366	65,760	8.93	16
17	Maintenance Workers	3,614	3,900	54,394	13.95	17
18	Housekeepers	4,346	4,642	41,540	8.95	18
19	Laundry	1,795	2,020	22,040	10.91	19
20	Administrator	1,689	1,986	66,380	33.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,757	2,890	40,849	14.13	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 C: Care Plan Coord	1,463	1,633	32,654	20.00	32
33	Other(specify) <u>Act Driver</u>	90	87	961	11.05	33
34	TOTAL (lines 1 - 33)	80,439	88,388	\$ 1,194,401 *	\$ 13.51	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	98	\$ 3,456	1-3	35
36	Medical Director	Contract	6,563	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,222	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	1,475	11-3	44
45	Social Service Consultant	Contract	1,475	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	98	\$ 16,191		49

C. CONTRACT NURSES

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

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

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

Facility Name & ID Number Henderson County Ret Center

0035246

Report Period Beginning:

01/01/14

Ending:

12/31/14

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. LSN \$2,336.73
- (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? 9
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,019 Line 10-2
- (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. \$ 107,729
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? Yes 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? n/a
- (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. \$ 9,388
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 10,731
- c. What percent of all travel expense relates to transportation of nurses and patients? 90
- 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? n/a
- 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: Bennett & Middendorf
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Henderson County Retirement Center, Inc.
#0035246
01/01/14 to 12/31/14

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$1,802.04
REPAIRS & MAINT LAUNDRY	\$932.34
REPAIRS & MAINT HSK	\$0.00
OUTSIDE SERVICES	\$14,464.85
REPAIRS & MAINT BUILDING	\$8,554.11
REPAIRS & MAINT EQUIP	\$2,123.55
REPAIRS & MAINT GROUNDS	\$1,204.56
REFUSE	\$3,940.98
REPAIRS & MAINT GEN/ADM	\$3,514.98
TOTAL	<u>\$36,537.41</u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$5,135.76
Board Minutes	\$350.00
Software Support	\$10,522.61
IVANS Medicare Billings	\$2,496.00
TOTAL	<u>\$18,504.37</u>

Schedule V. Line 14 & 25, Column 2 (90% to line 14)

Auto Exp. & Service	\$1,805.71
Auto Gas & Oil	\$6,570.16
Business Mileage Expense	\$714.13
TOTAL	<u>\$9,090.00</u>

Schedule V. Line 43, Column 3

Bad Debt	\$0.00
Rounding	\$0.00
TOTAL	<u>\$0.00</u>

Schedule V. Line 27, Column3

Data Process-Internet	\$526.58
Contributions	\$95.00
Misc Exp.	\$3,123.03
Rounding	-\$2.00
bank fees	\$9.00
	<u>\$3,751.61</u>

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Transportation Income-Pvt	\$1,842.50
Transportation Income-IDPA	\$10,730.72
Suppliments	\$3,984.00
WheelChair Rental	-\$25.00
Admission Income	\$1,200.00
Uniform Sales	\$0.00
Activities Program Income	\$0.00
Personal Purchase income	\$0.00
SLF Allocations-Clerical	\$2,499.96
SLF Allocations-Maintenance	\$9,999.96
Gain or Loss on Sale of Asset	\$250.00
Rebates	\$1,515.80
Dues	\$875.00
Misc. Income	\$58.26
Rounding	\$1.00
	<u><u>\$32,932.20</u></u>

Schedule XIX, Section F.

LSN	Dues	\$2,336.73
INHAA	Dues	\$100.00
Assoc of Nutrition & Food Service Prof	Dietary License	\$155.00
Insightful Food	Sanitation Course	\$140.00
IDFP	Salon Registration	\$40.00

Diana Doran	Certification fee for Good Standing	\$32.00
Wescom Solutions	Sandbox Database License	\$800.00
Good Ol Days	Subscription	\$21.98
Family Circle	Subscription	\$15.98
Hawkeye	Subscription	\$214.50
Midwest Living	Subscription	\$5.99
Smithsonian	Subscription	\$8.00
Reminisce	Subscription	\$14.98
Country Woman	Subscription	\$10.00
Poster Compliance	Subscription	\$69.00
Gary Grimm & Associates	Subscription	\$35.95
Henderson CO Economic Dev Corp	Dues	\$100.00
CLIA Lab Services	Lab Cert Fee	\$150.00
Creative Forecasters	Subscription	\$60.00
DM Webdesigners	Web Hosting Fee	\$334.95
Providersweb.com	Web Subscription/Dues	\$299.00
Med Pass	Subscription-Policy & Procedures	\$372.60
Activity Connect	Web Subscription/Dues	\$143.40
Mississippi Valley Human Resource Assoc	Dues	\$40.00
IDPH	Sanitation Lic.	\$105.00
IL Charity Buraeu	990-g Fee	\$15.00
Secretary of State	Fees	\$10.00
Secretary of State	Auto Stickers	\$101.00
Rounding		\$1.00
		<u>\$5,732.06</u>

Schedule XI, Section D.

Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Striaght Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
79 Patient Transport	Van	2012	\$9,105.00	\$1,821.00	\$1,821.00		5	\$5,463.00
80 Patient Transport	2014 Dodge Carav	2014	\$38,078.27	\$2,538.56	\$2,538.56		5	\$2,538.56
			<u>\$47,183.27</u>	<u>\$4,359.56</u>	<u>\$4,359.56</u>	<u>\$0.00</u>		<u>\$8,001.56</u>

Henderson County Retirement Center, Inc.

#0035246

01/01/14 to 12/31/14

Board Members

Diana Doran, Pres
Box 417
Carman, IL 61425

Judy Roessler
RR1, Box 11
Media, IL 61460

Sally Fisher
RR 1
Lomax, IL 61454

Tom Edmonds
RR 1, Box 129
Lomax, IL 61454

Mary Reed, Treas.
RR 1, Box 80
Little York, IL 61453

Tom Pullen
Box 199
Gladstone, IL 61437

Nancy Stevenson, Sec.
RR 1
Gladstone, IL 61437

David Gerst
RR 1, Box 111
Lomax, IL 61454

Ralph Tatge, Vice Pres.
Box 535
Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue
Zach Stamp

Diana Doran's insurance agency is the agent for the Commercial Package Policy.
The agency also provides the surety bond for the nursing home.

Henderson County Retirement Center, Inc.

#0035246

01/01/14 to 12/31/14

Reclassifications

1 Reclassify \$310.00 from In-Service Training to Seminar due to coding error.

2 Reclassify \$

3 Reclassify \$

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

Henderson County Retirement Center, Inc.
 #0035246
 01/01/14 to 12/31/14

Schedule V. Line 23, Column 3

When Attended	Vendor Name	Name of In-Service	Amount	
Feb 12 & Feb 26, 2014	Life Service Network Foundation	The Real Price of Waiting to Comply & How You Can	\$ 190.00	
1/29/2014	Life Service Network Foundation	Medicare 2014 Updates Webinar	\$ -	Paid from refund
1/29/2014	IHCA	RUG 48 Rules are Final...Are You Finally Ready?	\$ 155.00	
1/7/2014	Blessing Hospital	CPR Training - CPR Cards	\$ 22.00	
1/9/2014	Polaris Group	All About Quality Measures	\$ 90.90	
1/9/2014	Polaris Group	Pain, Risk Management	\$ 109.00	
2/10/2014	Polaris Group	MDS 3.0 Part 1 through Part 5 (CD's)	\$ 507.95	
3/18/2014	Life Service Network Foundation	Employment Law Update	\$ 109.00	
3/25/2014	Life Service Network Foundation	A Diffcult "Act" To Follow	\$ 109.00	
3/25/2014	Blessing Hospital	CPR Training - CPR Cards	\$ 4.00	
4/22/14 & 4/29/14	Polaris Group	Comprehensive Billing Series Part 3 & Part 6	\$ 236.95	
5/7-8/14	Insightful Food Safety	Food Safety Refresher	\$ 812.00	
5/20/2014	IL Health Care Association	PEPPER & CASPER (OSCAR) Reports	\$ 125.00	
5/20/2014	IL Health Care Association	PEPPER & CASPER (OSCAR) Reports - CEU's	\$ 30.00	
8/25/2014	Polaris Group	Final PPS Rules for October 1st	\$ 109.00	
8/14/2014	Polaris Group	Comprehensive Billing Series Part 2 MDS/RUG to Claim	\$ 109.00	
11/5/2014	Leading Age IL	MDS 3.0 Interviewing Revisited: Timely Tips & Techniques	\$ 109.00	
9/19/2014	Polaris Group	Medicare Documentation & Skilling Criteria	\$ 109.00	
11/11/2014	Polaris Group	Fall Prevention & Management	\$ 109.00	
		Total In Service Training	<u>\$ 3,045.80</u>	

Henderson County Retirement Center, Inc.
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Schedule V. Line 24, Column 3

Check Date	Who Attended	When Attended	Where Attended	Name of Seminar	Expense
1/10/2024	Bobbi Tapscott & Sharon Annegers	2/21/2014	Galesburg, IL	Geriatric Screening & Assessment	Fuel
1/10/2014	Bobbi Tapscott & Sharon Annegers	2/21/2014	Galesburg, IL	Geriatric Screening & Assessment	Registration
1/6/2014	Angie Cozadd, Sharon Annegers, Alicia Anderson	2/4/2014	Springfield, IL	Clinical Services in Post-acute Care	Registration
2/15/2014	No one attended - received refund - cancelled	1/23/2014	Springfield, IL	Clinical Services in Post-acute Care	Registration
3/13/2014	Angie Cozadd	3/11/2014	Peoria Heights, IL	LSN Seminar	Mileage
3/24/2014	Angie Cozadd	3/11/2014	Peoria Heights, IL	LSN Seminar	Meals
4/4/2014	Angie Cozadd, James Hetrick, Bobbi Tapscott	4/30/14-5/2/14	Chicago, IL	LSN Annual Conference & Expo	Registration
4/1/2014	Angie Cozadd, James Hetrick, Bobbi Tapscott	4/30/14-5/2/14	Chicago, IL	LSN Annual Conference & Expo	Am Trak
4/1/2014	Angie Cozadd, James Hetrick, Bobbi Tapscott	4/30/14-5/2/14	Chicago, IL	LSN Annual Conference & Expo	Hotel
5/8/2014	Angie Cozadd, James Hetrick, Bobbi Tapscott	4/30/14-5/2/14	Chicago, IL	LSN Annual Conference & Expo	Mileage
4/28/2014	Angie Cozadd, James Hetrick, Bobbi Tapscott	4/30/14-5/2/14	Chicago, IL	LSN Annual Conference & Expo	Cab Fare
4/28/2014	Angie Cozadd, James Hetrick, Bobbi Tapscott	4/30-5-2-14	Chicago, IL	LSN Annual Conference & Expo	Meals
4/25/2014	Dianne Kircher, Bobbi Tapscott, Rober Weyant	4/14/2014	Burlington, IA	Employment Law Class	Registration
4/17/2014	Angie Cozadd	5/8/2014	Bloomington, IL	An Insider's View of the Survey Process & Ombudsman Program	Registration
6/3/2014	Angie Cozadd	5/8/2014	Bloomington, IL	An Insider's View of the Survey Process & Ombudsman Program	Refund
4/24/2014	Angie Cozadd, Sharon Annegers, Alicia Anderson	4/21/2014	Knoxville, IL	IDPH-Townhall Meeting	Mileage
4/24/2014	Angie Cozadd, Sharon Annegers, Alicia Anderson	4/21/2014	Knoxville, IL	IDPH-Townhall Meeting	Meals
4/24/2014	Alicia Anderson & Wendi Noble	5/24/2014	Chicago, IL	Relias Training Seminar	Am Trak
4/24/2014	Alicia Anderson & Wendi Noble	5/21/2014	Chicago, IL	Relias Training Seminar	Hotel
5/21/2014	Alicia Anderson & Wendi Noble	5/21/2014	Chicago, IL	Relias Training Seminar	Am Trak
5/21/2014	Alicia Anderson & Wendi Noble	5/21/2014	Chicago, IL	Relias Training Seminar	Cab Fare
5/21/2014	Alicia Anderson & Wendi Noble	5/21/2014	Chicago, IL	Relias Training Seminar	Meals
5/8/2014	Robert Weyant, Angie Cozadd, Sharon Annegers, Alicia Anderson	5/8/2014	Macomb, IL	Leader Cast	Registration
5/9/2015	Robert Weyant, Angie Cozadd, Sharon Annegers, Alicia Anderson	5/8/2014	Macomb, IL	Leader Cast	Meals
5/14/2014	Dianne Kircher	6/17-19/14	Chicago, IL	Chicago Advanced Billing Training Workshop for LTC	Registration
6/16/2014	Dianne Kircher	6/17-19-14	Chicago, IL	Chicago Advanced Billing Training Workshop for LTC	Fuel
6/19/2014	Dianne Kircher	6/17-19-14	Chicago, IL	Chicago Advanced Billing Training Workshop for LTC	Meals
6/19/2014	Dianne Kircher	6/17-19-14	Chicago, IL	Chicago Advanced Billing Training Workshop for LTC	Hotel
6/19/2014	Dianne Kircher	6/17-19/14	Chicago, IL	Chicago Advanced Billing Training Workshop for LTC	Tolls
6/14/2014	Alicia Anderson & Sharon Annegers	7/1/2014	Springfield, IL	Rugs IV 48 Grouper - Are You Ready for the Audit Process:	Registration

7/1/2014	Alicia Anderson & Sharon Annegers	7/1/2014	Springfield, IL	Rugs IV 48 Grouper - Are You Ready for the Audit Process:	Hotel
7/1/2014	Alicia Anderson & Sharon Annegers	7/1/2014	Springfield, IL	Rugs IV 48 Grouper - Are You Ready for the Audit Process:	Meals
7/1/2014	Alicia Anderson & Sharon Annegers	7/1/2014	Springfield, IL	Rugs IV 48 Grouper - Are You Ready for the Audit Process:	Mileage
8/21/2014	Marke Seitz Robert Wayland, Shelby Newman, Erin Bailey,	8/21/2014	Galesburg, IL	Restorative Nursing Assistant Training	Mileage
8/14/2014	Marke Seitz	8/21/2014	Galesburg, IL	Restorative Nursing Assistant Training	Registration
8/6/2014	Joyce Hetrick, Carole Dillon	8/1/2014	Moline, IL	Rick Ramirez 8/1/14 Seminar	Registration
8/18/2014	Dianne Kircher	9/23/2014	Springfield, IL	All Things Medicare Road Show	Registration
9/23/2014	Dianne Kircher & Bobbi Tapscott Robert Weyant, Nikki Baker, Victoria Tapscott &	9/23/2014	Springfield, IL	All Things Medicare Road Show & HFS Training on ABE	Meals
9/24/2014	Bobbi Tapscott Robert Weyant, Nikki Baker, Victoria Tapscott &	9/24/2014	Waterloo, IA	Martin Bros. Food Show	Meals
9/24/2014	Bobbi Tapscott	9/24/2014	Waterloo, IA	Martin Bros. Food Show	Fuel
11/25/2014	Joyce Hetrick, Carole Dillon	11/6/2014	Moline, IL	Rick Ramirez 11/6/14 Seminar	Registration
1/14/2014	Joyce Hetrick, Carole Dillon	11/6/2014	Moline, IL	Rick Ramirez 11/6/14 Seminar	Supplies
11/13/2014	Casey Mowen & Heather Haynes	11/24/2014	Galesburg, IL	WTA Program	Registration
12/5/2014	Suburban Law Enforcement Symposium	12/16/2014	Springfield, IL	Criminal History Record Information Training Symposium for Non-Criminal Justice Users	Registration
12/16/2014	Suburban Law Enforcement Symposium	12/16/2014	Springfield, IL	Criminal History Record Information Training Symposium for Non-Criminal Justice Users	Meals
				Total Seminars	

Amount	Totals
\$ 18.13	
\$ -	\$ 18.13
\$ 310.00	
\$ (496.00)	\$ (186.00)
\$ 38.37	
\$ 10.45	\$ 48.82
\$ 988.00	
\$ 80.00	
\$ 420.00	
\$ 46.80	
\$ 115.00	
\$ 183.00	\$ 1,832.80
\$ 90.00	\$ 90.00
\$ 165.00	
\$ (165.00)	\$ -
\$ 80.00	
\$ 62.00	\$ 142.00
\$ 120.00	
\$ 250.22	
\$ 22.00	
\$ 8.25	
\$ 38.09	\$ 438.56
\$ 240.00	
\$ 50.00	\$ 290.00
\$ 779.00	
\$ 86.55	
\$ 78.91	
\$ 429.57	
\$ 14.40	\$ 1,388.43
\$ 208.00	

\$ 111.44	
\$ 112.92	
\$ 140.40	\$ 572.76
\$ 33.30	
\$ 720.00	\$ 753.30
\$ 295.00	\$ 295.00
\$ 150.00	
\$ 13.35	\$ 163.35
\$ 33.02	
\$ 48.40	\$ 81.42
\$ 295.00	
\$ 5.26	\$ 300.26
\$ 400.00	\$ 400.00
\$ 30.00	
\$ 10.14	\$ 40.14
\$ 6,668.97	\$ 6,668.97