FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0048132

Facility Name: Heritage Health Elgin

Address: 355 Raymond Street (Number) Elgin (City) 60120 (Zip Code)

County: Kane

Telephone Number: (847) 697-6636 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,001	3,322	2,297	29,620	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,001	3,322	2,297	29,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.33%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

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

I. On what date did you start providing long term care at this location?
Date started July 2006

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,297

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	268,771	24,390		293,161		293,161	5,015	298,176			1
2	Food Purchase		212,243		212,243		212,243	29	212,272			2
3	Housekeeping	108,342	48,834		157,176		157,176	36	157,212			3
4	Laundry	45,570	18,576		64,146		64,146		64,146			4
5	Heat and Other Utilities			110,713	110,713		110,713	1,302	112,015			5
6	Maintenance	120,235	69,268	66,304	255,807		255,807	15,339	271,146			6
7	Other (specify):*											7
8	**TOTAL General Services**	542,918	373,311	177,017	1,093,246		1,093,246	21,721	1,114,967			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,945,445	96,493	31,518	2,073,456		2,073,456	(15,691)	2,057,765			10
10a	Therapy		409,204	648,319	1,057,523	(414,262)	643,261		643,261			10a
11	Activities	71,420	8,375		79,795		79,795		79,795			11
12	Social Services	42,596		3,228	45,824		45,824		45,824			12
13	CNA Training		4,750		4,750		4,750	893	5,643			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,059,461	518,822	695,065	3,273,348	(414,262)	2,859,086	(14,798)	2,844,288			16
	C. General Administration											
17	Administrative	108,909			108,909		108,909		108,909			17
18	Directors Fees											18
19	Professional Services			334,418	334,418		334,418	(268,050)	66,368			19
20	Dues, Fees, Subscriptions & Promotions			88,895	88,895	(51,465)	37,430	(26,908)	10,522			20
21	Clerical & General Office Expenses	309,161	37,821	33,113	380,095		380,095	300,087	680,182			21
22	Employee Benefits & Payroll Taxes			634,378	634,378		634,378	44,813	679,191			22
23	Inservice Training & Education			8,282	8,282		8,282	664	8,946			23
24	Travel and Seminar			5,068	5,068		5,068	(69)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,903	74,903		74,903	12,979	87,882			26
27	Other (specify):* **Lost resident items**			25,000	25,000		25,000	(24,000)	1,000			27
28	**TOTAL General Administration**	418,070	37,821	1,204,057	1,659,948	(51,465)	1,608,483	39,516	1,647,999			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,020,449	929,954	2,076,139	6,026,542	(465,727)	5,560,815	46,439	5,607,254			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 Elgin #0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							148,059	148,059			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,625	31,625		31,625	9,008	40,633			32
33	Real Estate Taxes							50,038	50,038			33
34	Rent-Facility & Grounds			411,726	411,726		411,726	(406,354)	5,372			34
35	Rent-Equipment & Vehicles			29,323	29,323		29,323	7,487	36,810			35
36	Other (specify):*											36
37	TOTAL Ownership			472,674	472,674		472,674	(191,762)	280,912			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					414,262	414,262	(24,012)	390,250			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					465,727	465,727	(24,012)	441,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,020,449	929,954	2,548,813	6,499,216		6,499,216	(169,335)	6,329,881			45

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,344)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(6,322)			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	(24,000)			24
25	Fund Raising, Advertising and Promotional	(33,855)			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)**	$ (83,521)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(85,814)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (85,814)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (169,335)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Heritage Health Elgin

ID# **0048132**

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		0	19	22
23				23
24		(24,000)	27	24
25		(33,855)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(57,855)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Elgin **#** 0048132 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,015	0	0	0	0	0	0	0	0	5,015	1
2	Food Purchase	0	0	29	0	0	0	0	0	0	0	0	29	2
3	Housekeeping	0	0	36	0	0	0	0	0	0	0	0	36	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,302	0	0	0	0	0	0	0	0	1,302	5
6	Maintenance	0	0	15,339	0	0	0	0	0	0	0	0	15,339	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	21,721	0	0	0	0	0	0	0	0	21,721	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	(16,282)	591	0	0	0	0	0	0	0	0	(15,691)	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	893	0	0	0	0	0	0	0	0	893	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	(16,282)	1,484	0	0	0	0	0	0	0	0	(14,798)	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	(286,056)	18,006	0	0	0	0	0	0	0	0	(268,050)	19
20	Fees, Subscriptions & Promotions	(33,855)	0	6,947	0	0	0	0	0	0	0	0	(26,908)	20
21	Clerical & General Office Expenses	0	0	300,087	0	0	0	0	0	0	0	0	300,087	21
22	Employee Benefits & Payroll Taxes	0	0	44,813	0	0	0	0	0	0	0	0	44,813	22
23	Inservice Training & Education	0	(280)	944	0	0	0	0	0	0	0	0	664	23
24	Travel and Seminar	(6,322)	0	6,253	0	0	0	0	0	0	0	0	(69)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,979	0	0	0	0	0	0	0	0	12,979	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	**TOTAL General Administration**	(64,177)	(286,336)	390,029	0	0	0	0	0	0	0	0	39,516	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,177)	(302,618)	413,234	0	0	0	0	0	0	0	0	46,439	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	129,627	0	18,432	0	0	0	0	0	0	0	148,059	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,344)	28,410	0	(58)	0	0	0	0	0	0	0	9,008	32
33	Real Estate Taxes	0	50,038	0	0	0	0	0	0	0	0	0	50,038	33
34	Rent-Facility & Grounds	0	(411,726)	0	5,372	0	0	0	0	0	0	0	(406,354)	34
35	Rent-Equipment & Vehicles	0	0	0	7,487	0	0	0	0	0	0	0	7,487	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,344)	(203,651)	0	31,233	0	0	0	0	0	0	0	(191,762)	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	(24,012)	0	0	0	0	0	0	0	0	0	(24,012)	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	(24,012)	0	0	0	0	0	0	0	0	0	(24,012)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(83,521)	(530,281)	413,234	31,233	0	0	0	0	0	0	0	(169,335)	45

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] 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	10	Adjustment for Related Organiza	$	GreenTree Pharmacy	0.00%	$ (16,282)	$ (16,282)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(280)	(280)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(24,012)	(24,012)	3
4	V	19	Adjustment for Related Organization	286,056	Heritage Operations Group, LLC	0.00%		(286,056)	4
5	V								5
6	V	34	Adjustment for Related Organization	411,726	Heritage Manor Real Estate, LLC	0.00%		(411,726)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		50,038	50,038	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		23,637	23,637	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		129,627	129,627	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,773	4,773	10
11	V								11
12	V								12
13	V								13
14	Total			$ 697,782			$ 167,501	$ * (530,281)	14

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [x] 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)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 5,015	15
16	V	2	Food Purchase					29	16
17	V	3	Housekeeping					36	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,302	19
20	V	6	Maintenance					15,339	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					591	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					893	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					18,006	31
32	V	20	Fees, Subscription, Promotions					6,947	32
33	V	21	Clerical & General Office Expenses					300,087	33
34	V	22	Employee Benefits & Payroll Taxes					44,813	34
35	V	23	Inservice Training & Education					944	35
36	V	24	Travel and Seminar					6,253	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,979	38
39	Total			$			$ 0	$ * 413,234	39

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [x] 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)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$	$ 0	15
16	V	30	Depreciation					18,432	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					(58)	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,372	20
21	V	35	Rent-Equipment & Vehicles					7,487	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 31,233	39

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Sole Member		100.00					$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Heritage Operations Group
Street Address: Box 3188
City / State / Zip Code: Bloomington, IL 61701
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,835	27	$ 151,240	$ 150,308	94	$ 5,015	1
2	2	Food Purchase	Beds	2,835	27	878	0	94	29	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	94	36	3
4	4	Laundry	Beds	2,835	27	0	0	94	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	94	1,302	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	94	15,339	6
7	7	Other	Beds	2,835	27	0	0	94	0	7
8	9	Medical Director	Beds	2,835	27	0	0	94	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	94	591	9
10	11	Activities	Beds	2,835	27	0	0	94	0	10
11	12	Social Service	Beds	2,835	27	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	94	893	12
13	14	Program Transportation	Beds	2,835	27	0	0	94	0	13
14	15	Other	Beds	2,835	27	0	0	94	0	14
15	17	Administrative	Beds	2,835	27	0	0	94	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	94	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	94	18,006	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	94	6,947	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	94	300,087	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,835	27	1,351,528	0	94	44,813	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	94	944	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	94	6,253	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0	94	12,979	24
25	TOTALS					$ 12,462,987	$ 8,837,683		$ 413,234	25

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,835	27	$	$	94	$	1
2	30	Depreciation	Beds	2,835	27	555,915		94	18,432	2
3	31	Amortization of Pre-Op & Org	Beds	2,835	27			94		3
4	32	Interest	Beds	2,835	27	(1,746)		94	(58)	4
5	33	Real Estate Taxes	Beds	2,835	27			94		5
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022		94	5,372	6
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798		94	7,487	7
8	36	Other	Beds	2,835	27			94		8
9	38	Medically Nec Transportation	Beds	2,835	27			94		9
10	39	Ancillary Service Centers	Beds	2,835	27			94		10
11	40	Barber and Beauty Shops	Beds	2,835	27			94		11
12	41	Coffee and Gift Shops	Beds	2,835	27			94		12
13	42	Other	Beds	2,835	27			94		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 941,989	$		$ 31,233	25

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		x	Mortgage			$	$			$ 23,637	1
2	Bank of America		x	Loan Fee Amortization							4,773	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							31,625	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 60,035	9
	B. Non-Facility Related*											
10	Interest Income										(19,344)	10
11												11
12	Allocated Corporate										(58)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (19,402)	14
15	TOTALS (line 9+line14)						$	$			$ 40,633	15

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

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

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 50,038	2
3. Under or (over) accrual (line 2 minus line 1).		$ 50,038	3
4. Real Estate Tax accrual used for 2015 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.		$ 50,038	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011	45,693	9
2012	45,145	10
2013	41,653	11
2014	50,038	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 48132

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0624201003		$ 47,264.94	$ 47,264.94
2.	0624201002		$ 1,577.30	$ 1,577.30
3.	0624201004		$ 1,195.88	$ 1,195.88
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,038.12	$ 50,038.12

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,275 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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 [x] (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 [x] 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				$ 80,000	1
2					2
3	TOTALS			$ 80,000	3

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94				$ 720,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1989 Improvements			1989	180,739						9
10	1990 Improvements			1990	658,346						10
11	1990 Improvements			1990	4,320						11
12	1991 Improvements			1991	52,989						12
13	1992 Improvements			1992	6,777						13
14	1993 Improvements			1993	54,564						14
15	1994 Improvements			1994	81,347						15
16	1995 Improvements			1995	146,394						16
17	Remodel Resident Day Room/Nurses Station			1996	23,749						17
18	Interior Rehab			1997	751						18
19	Electric Water Heater			1997	3,965						19
20	Booster Heater			1997	1,622						20
21	Water Heater and Storage Tank			1998	6,485						21
22											22
23	Water Heater			1999	4,750						23
24	Code Alert System			1999	1,570						24
25	Resident Room Remodel--Material and Labor			1999	2,571						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation					18,432		18,432			33
34	Book Depreciation					108,310		108,310			34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	South Wing Remodel -- Labor / Materials	2000	$ 14,334	$		$	$	$	37
38	Door	2000	1,535						38
39	Dry Chemical Extinguisher	2000	1,746						39
40									40
41	Water Heater	2001	4,935						41
42	Valve thermometer	2001	4,520						42
43	A/C Unit	2001	3,319						43
44	Hallway Carpet and Tile Material and Labor	2001	28,843						44
45	Wallpaper	2001	2,390						45
46	Nurse Call System	2001	21,612						46
47									47
48	Hallway and Room Carpet and Tile Material	2002	74,533						48
49	Labor	2002	68,734						49
50	Professional Fees	2002	16,497						50
51	Kitchen Pipe	2002	1,830						51
52	Shower Repairs	2002	5,063						52
53	A/C Unit	2002	5,864						53
54	Bathroom Rehab	2002	750						54
55	Condensor	2002	1,600						55
56	Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57									57
58	Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59	Exterior Door	2003	320						59
60	Parking Lot Sealer	2003	4,469						60
61	Door Security	2003	2,160						61
62	Ductwork	2003	6,628						62
63	compressor	2003	1,195						63
64	Blower Unit	2003	1,784						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,324,370	$ 126,742		$ 126,742	$	$	70

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,324,370	$ 126,742		$ 126,742	$	$	1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7	Fire Alarm	2006	1,714						7
8	Parking Lot	2006	2,344						8
9	Remodel Corridor --paint	2006	4,028						9
10	Water Main	2006	3,250						10
11									11
12	Roof	2007	94,451						12
13	Central Corridor paint, tile	2007	49,685						13
14	Plumbing fixtures	2007	2,400						14
15	Rooftop heat/cool unit	2007	5,565						15
16									16
17	A/C Units	2008	19,600						17
18	4 Ton A/C Unit	2008	2,600						18
19	HVAC Rooftop Unit	2008	11,000						19
20									20
21	Patio	2009	11,693						21
22	Front Entry Doors	2009	13,529						22
23	Front Office Carpet and Window Treatments	2009	3,864						23
24									24
25	Cat5 cable/wire facility	2010	6,607						25
26									26
27	Electric water heater	2011	11,750						27
28	Sign	2011	2,500						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,576,726	$ 126,742		$ 126,742	$	$	34

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,576,726	$ 126,742		$ 126,742	$	$	1
2									2
3	Smoke Detector	2012	6,090						3
4	Aiphone	2012	7,030						4
5	Walk in Freezer	2012	5,210						5
6									6
7	Fire Sprinler System	2013	167,700						7
8	Lighting Retrofit	2013	13,876						8
9	New 60 kw Generator	2013	75,234						9
10	Install Door Alarms	2013	5,252						10
11	Fire Alarm Control Panel	2013	12,311						11
12	Parking Lot Replacement	2013	72,770						12
13	Cabling for Wireless Network	2013	11,960						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,954,159	$ 126,742		$ 126,742	$	$	34

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 801,313	$ 21,317	$ 21,317	$		$	71
72	Current Year Purchases	31,541						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 832,854	$ 21,317	$ 21,317	$		$	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)	$ 3,867,013	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,059	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,059	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None
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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 29,323 Description: Televisions, Mattresses, Concentrators
    (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 Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 297,534	$		$ 297,534	1
2	Licensed Speech and Language Development Therapist		hrs			19,480			19,480	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			322,168	4,079		326,247	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				405,125		405,125	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,137			9,137	13
14	TOTAL			$		$ 648,319	$ 409,204		$ 1,057,523	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 800	$	1
2	Cash-Patient Deposits	38,116		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,283,114		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,413		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(384,803)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 968,640	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 968,640	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 315,306	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,116		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	239,615		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,613		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	27,843		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 628,493	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 628,493	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 340,147	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 968,640	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Elgin **#** 0048132 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 308,058	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 308,058	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,089	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)**	$ 32,089	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)**	$ 340,147	24 *

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,874,858	1
2	Discounts and Allowances for all Levels	(1,996,551)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,878,307	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,933,098	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,933,098	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	700,556	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 700,556	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,344	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,531,305	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,093,246	31
32	Health Care	3,273,348	32
33	General Administration	1,659,948	33
	B. Capital Expense		
34	Ownership	472,674	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,499,216	40
41	**Income before Income Taxes (line 30 minus line 40)****	32,089	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 32,089	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 Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,923	2,024	$ 88,167	$ 43.56	1
2	Assistant Director of Nursing	3,830	4,032	159,822	39.64	2
3	Registered Nurses	14,135	14,898	520,557	34.94	3
4	Licensed Practical Nurses	7,426	7,817	217,676	27.85	4
5	CNAs & Orderlies	56,645	59,626	902,324	15.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,771	2,917	56,899	19.51	8
9	Activity Director					9
10	Activity Assistants	6,533	6,877	71,420	10.39	10
11	Social Service Workers	1,930	2,032	42,596	20.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,479	20,504	268,771	13.11	15
16	Dishwashers					16
17	Maintenance Workers	5,721	6,022	120,235	19.97	17
18	Housekeepers	10,351	10,896	108,342	9.94	18
19	Laundry	3,587	3,776	45,570	12.07	19
20	Administrator	1,976	2,080	108,909	52.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,950	12,579	309,161	24.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,257	156,080	$ 3,020,449 *	$ 19.35	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,148		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,571		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,228		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,947		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Hartmann			$ 108,909
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,909

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group		$ 286,076
ADP		1,044
Consova		837
Legal adj to Zero		46,461
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 334,418

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,264
Unemployment Compensation Insurance	28,910
FICA Taxes	231,064
Employee Health Insurance	329,905
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	14,235
Central Office Allocation	44,813
TOTAL (agree to Schedule V, line 22, col.8)	$ 679,191

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	692
Health Care Worker Background Check	
(Indicate # of checks performed)	1,370
Patient Background Checks	
PR	19,745
Dues & Subscriptions	7,506
License & Fees	1,187
Central Office Allocation	6,947
Less: Public Relations Expense	(19,745)
Non-allowable advertising	(7,180)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,522

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,422
	81
Seminar Expense	565
	(69)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 01/01/15 Ending: 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

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

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **51,465**
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. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sulaski & Webb**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None claimed**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount
1009	PETTY CASH	800					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	1,283,114					
1110	MEDICARE RECEIVABLES						
1125	IPA INCOME RECEIVABLE						
1130	MEDICARE COST REPORT						
1135	ACCOUNTS RECEIVABLE-IC						
1140	UNAPPLIED CASH RECEIPTS						
1145	A/R SUSPENSE-REFUNDS						
1190	ACCRUED INTEREST REC						
1200	PREPAID INSURANCE	31,413					
1220	OTHER PREPAID EXPENSES						
1300	FOOD INVENTORY						
1310	SUPPLIES INVENTORY						
1409	LAND	0					
1450	FURNITURE & EQUIPMENT	0					
1460	ACCUM DEPR-FURN & EQU	0					
1475	BUILDING & IMPROVEMEN	0					
1490	ACCUM DEPR-BUILDING	0					
1530	RESIDENT FUNDS	38,116					
1550	LOAN FEES	0					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	-384,803					
2010	ACCOUNTS PAYABLE	-315,306					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	-41,953					
2110	ACCRUED VACATION PAY	-197,662					
1,009	1,009 PETTY C	800					
1,100	1,100 ACCTS R	1,461,791					
1,101	1,101 ALLOW.	(178,677)					
1,110	1,110 ACCTS RECEIV-M/C						
1,125	1,125 ACCTS RECEIV-IPA						
1,135	1,135 ACCTS RECEIV-IC						
1,140	1,140 UNAPPLIED CASH RECEIPTS						
1,145	1,145 A/R SUSPENSE-REFUNDS						
1,200	1,200 PREPAID	31,413					
1,220	1,220 OTHER PREPAID EXPENSES						
1,300	1,300 DIETARY INVENTORY						
1,310	1,310 SUPPLIES INVENTORY						
1,320	1,320 LINEN INVENTORY						
1,409	1,409 LAND	0					
1,450	1,450 FURNITU	0					
1,460		0					
1,475	1,475 CODE AI	0					
1,490	1,490 ACCUM I	0					
1,530	1,530 RESIDEN	38,116					
1,550	1,550 LOAN FE	0					
1,551	1,551 LOAN FEES ADDED						
1,850	1,850 INTERCC	(384,803)					
2,010	2,010 ACCOUN	(315,306)					
2,100	2,095 BONUSES PAYABLE						
2,100	2,100 ACCRUE	(41,953)					
2,100	2,100 PR CLEARING-BENEFITS						
2,100	2,100 PR CLEARING-LABOR						
2,110	2,110 ACCRUE	(197,662)					
2,120	2,120 U.C. TAX	0					

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-7,613	-7,613
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYA	0	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-27,843	
2350	REAL ESTATE TAX PAYAB	0	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-38,116	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-308,058	
2970	PROFIT/LOSS FOR PERIOD	-32,089	
3007.1	PATIENT DAYS-PRIVATE	3,322	

2,125	2,125	FICA TA	(7,613)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REF	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETE	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE G	
2,300	2,300	ACCRUE	0
2,320	2,320	IPA PAYI	(27,843)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DE	
2,512	2,512	DUE TO I	(38,116)
2,600	2,600	LASALLI	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DE	
2,720	2,720	RETAINE	(308,058)
		net incom	(32,089)
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	24,001					3,007
3007.3		PATIENT DAYS-MEDICARE	2,297					3,007
3007.4		PATIENT DAYS-CONVERSION						3,007
3007.5		PATIENT DAYS-LICENSED						3,007
3007.6		PATIENT DAYS-TOTAL						3,007
3010	1	BASIC CHARGE-PRIVATE &	-5,856,429	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	-17,020	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	-700,556	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-1,933,098	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	1,996,551	0	0	0	0	3,411
3411	2	MEDICAID PART B DISCOUNT		0	0	0	0	3,420
3420	2	MEDICARE DISCOUNTS		0	0	0	0	3,500

3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0			3,520
3520		16	RENT INCOME	0		6	0	6	0			3,530
3530		13	BEAUTY SHOP	0		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	0		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-1,409		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	0		0	0	0	0			4,110
3600		21	MISC INCOME	0		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	286,464	309,161	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	108,909	108,909	17	1	0	0			4,120
4115			VACATION & SICK - G&A	22,697		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	14,235	634,378	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLARSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLARSHIP	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	37,821	37,821	21	2	0	0			4,275
4260			TELEPHONE	33,113	33,113	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	8,282	8,282	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	4,422	5,068	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	81		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	565		24	3	19	-6,322	***		4,289
4290			HELP WANTED ADVERTISI	692	88,895	20	3	0	0		-51,465	4,290
4291			PROMOTIONAL ADVERTIS	6,930		20	3	25	-6,930			4,291
4292			PUBLIC RELATIONS	19,745		20	3	25	-19,745			4,292
4300			LICENSES & FEES	52,652		20	3	17	-70			4,300
4310			DUES & SUBSCRIPTIONS	7,506		20	3	17	-7,110			4,310
4320			CONTRIBUTIONS	0		27	3	20	0			4,320
4350			PROFESSIONAL FEES	48,362	334,418	19	3	22	0			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	2,148		10	3	0	0	4,364
4363	PHARMACIST FEES	5,571		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,228	3,228	12	3	0	0	4,383
4370	TV RENTAL	25,957		35	3	5	0	4,390
4380	INCOME TAXES		25,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,370		20	3	26	0	4,401
4400	PAYROLL TAXES	248,669		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	11,305		22	3	0	0	4,420
4410	GROUP INSURANCE	329,905		22	3	0	0	4,430
4420	LIABILITY INSURANCE	74,903	74,903	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	30,264		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	286,056		19	3	34	0 **	4,460
4460	BAD DEBTS	24,000		27	3	24	-24,000	4,461
4470	LOST ITEMS-RESIDENTS	1,000		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	3,366	29,323	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	111,991	120,235	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	8,244		6	1	0	0	4,510
5130	ELECTRIC	77,373	110,713	5	3	0	0	4,600
5131	NATURAL GAS	4,648		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	28,692		5	3	0	0	5,130
5134	TRASH COLLECTION	13,235	66,304	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	5,337	69,268	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	63,931		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	53,069		6	3	0	0	5,140
5210	DIETARY WAGES	250,325	268,771	1	1	0	0	5,160
5220	DIETARY SICK & VAC	18,446		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	212,243	212,243	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,858	24,390	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	7,412		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	13,120		1	2	0	0	5,260
5295	MEAL CREDIT	0		2	2	0	0	5,270
5310	LAUNDRY WAGES	43,241	45,570	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,329		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	13,324	18,576	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,252		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	103,452	108,342	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	4,890		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	48,356	48,834	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	478		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,945,445	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	465,089		10	1	0	0	6,020
6030	DON WAGES	88,167		10	1	0	0	6,030
6035	ADON	159,822		10	1	0	0	6,035
6040	RN SICK & VACATION	55,468		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	203,268		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	14,408		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC	841,555		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	60,769		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 WA	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	4,750	4,750	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	53,819		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,080		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	32,607	96,493	10	2	0	0	7,281
6295	NURSING SUPPLIES	62,684		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	1,202		10	2	0	0	7,391
6490	NURSING OTHER	23,799	31,518	10	3	0	0	7,393
7280	DRUG PURCHASES	142,131	409,204	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	262,994		39	2			7,540
7380	LABORATORY SERVICES	9,137	648,319	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	68,760	71,420	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	2,660		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	8,375	8,375	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	322,168		39	3	0	0 ***	7,890
7660	PT SUPPLIES	4,079		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	39,498	42,596	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	3,098		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	297,534		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	19,480		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	411,726	411,726	34	3	0	0	

8120	INTEREST EXPENSE	31,625	31,625	32	3	14	-19,344	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-19,344		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		6,479,872	6,499,216					
			19,344					
GRAND TOTALS		-32,089					-83,521	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	3,322	3,322
IPA	24,001	24,001
medicare	2,297	2,297
		29,620

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BT

BT

3,007 PATIENT 3,322

3,007	PATIENT	24,001
3,007	PATIENT	2,297
		0
3,010	BASIC CI	(5,856,429)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSINC	(17,020)
3,081	NURSINC	0
3,082	NURSINC	0
3,083	NURSINC	0
3,100	DRUGS-N	(700,556)
		0
3,110	PHYSICA	(1,933,098)
		0
3,112	PHYSICA	0
3,113	PHYSICA	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTH	0
3,411	MEDICA	0
3,420	MEDICA	1,777,779

3,520	RENT INCOME	
3,530	BEAUTY SHOP	
		0
3,570	VENDING INCOME & EXPENSE	
3,590	EQUIPMI	(1,409)
3,595	RESIDEN	0
3,600	MISC INC	0
4,110	G&A WA	286,464
4,111	ADMINIS	108,909
4,115	G&A PTC	22,697
4,120	EMPLOY	13,440
4,130	EMPLOYEE SCHOLARSHIPS	
4,135	EMPLOYEE SCHOLARSHIPS-COSTS	
4,250	OFFICE S	18,238
4,255	POSTAGI	7,819
4,260	TELEPHC	33,113
4,275	TRAININ	8,282
		0
4,280	GENERA	4,422
4,281	MEAL EX	81
4,285	EDUCAT	565
4,289	MEETINGS EXPENSE	
4,290	HELP WA	692
4,291	PROMOT	6,930
4,292	PUBLIC I	19,745
4,300	LICENSE	52,652
4,310	DUES & S	7,506
4,320	CONTRIE	0
4,350	PROFESS	48,362
4,355	MEDICAI	12,000
		2,148
		5,571

4,364	SOCIAL S	3,228
4,370	TV RENT	25,957
4,383	BACKGR	1,370
4,390	OTHER TAXES	
4,400	PAYROL	248,669
4,401	PAYROL	11,305
4,410	GROUP I	329,905
4,420	LIABILIT	74,903
4,430	WORKM.	29,131
4,435	W/C-FIRS	271
4,436	DRUG TE	862
4,450	MANAGI	286,056
4,460	BAD DEI	24,000
4,461	BAD DEI	218,772
4,470	LOST ITI	1,000
4,475	UNIFORM	795
4,486	SERVICE	25,769
4,490	MISC EX	138
4,496	MISC. M.	11,764
4,510	REAL ES	0
4,600	LEASED	3,366
5,110	MAINTEI	111,991
5,120	MAINTEI	8,244
5,130	ELECTRI	77,373
5,131	NATURA	4,648
5,133	WATER &	28,692
5,134	TRASH C	13,235
5,140	PROP/PL.	5,337
5,160	GENERA	63,931
5,165	MAINTEI	27,300
5,210	DIETARY	250,325
5,220	DIETARY	18,446
5,248	FOOD PU	212,105

5,250	SUPPLIE	3,858
5,260	REPLACI	7,412
5,270	KITCHEN	13,120
5,295	MEAL INCOME	
5,310	LAUNDR	43,241
5,340	LAUNDR	2,329
5,370	REPLACI	13,324
5,390	SUPPLIE	5,252
5,410	HOUSEK	103,452
5,440	HOUSEK	4,890
5,480	SUPPLIE	48,356
5,490	SUPPLIE	478
6,020	RN WAG	465,089
6,030	DON WA	88,167
6,035	ADON W	159,822
6,040	RN PTO &	55,468
6,120	LPN WAG	203,268
6,140	LPN PTO	14,408
6,220	AIDES W	841,555
6,240	AIDES PT	60,769
6,245		
		0
		4,750
		0
6,270	REHAB V	53,819
6,275	REHAB P	3,080
6,290	NURSING	32,607
6,295	NURSING	62,684
6,390	REPLACI	1,202
6,490	OTHER	23,799

7,280	DRUG PU	142,131
7,281	DRUG PU	262,994
7,380	LABORA	1,932
7,390	X-RAY S	7,205
		0
7,510	ACTIVIT	68,760
7,540	ACTIVIT	2,660
7,590	ACTIVIT	8,375
7,620	PHYSICA	322,168
7,660	P.T. SUPI	4,079
7,710	SOCIAL S	39,498
7,720	SOCIAL S	3,098
7,730	SOCIAL S	0
7,740	OCCUPA	297,534
7,770	SPEECH	19,480
7,820	BEAUTIC	0
		0
		0
8,120	INTERES	0
		31,625
8,130	DEPRECI	0
		0
9,510	INTERES	(19,344)
9,520	MISC NO	0
4,220		0
8,100		411,726
9,702		0
5,230		0
		(32,089)

Expenses Fixed Assets

0