

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0048108</u></p> <p>Facility Name: <u>Heritage Health Mendota</u></p> <p>Address: <u>1201 First Avenue</u> <u>Mendota</u> <u>61342</u> Number City Zip Code</p> <p>County: <u>LaSalle</u></p> <p>Telephone Number: <u>(815) 539-6745</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2007</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dave Underwood</u> Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/15</u> to <u>12/31/15</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David M Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>EVP & CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>David M Underwood</u>			(Title) <u>EVP & CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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Paid Preparer	(Signed) _____	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) _____																																									
	(Telephone) () _____ Fax # () _____																																									

Facility Name & ID Number Heritage Health Mendota

0048108 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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	13,356	9,928	365	23,649	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,356	9,928	365	23,649	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.45%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started July 2007

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 365

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

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	185,707	14,143		199,850		199,850	5,281	205,131		1
2	Food Purchase		178,529		178,529		178,529	31	178,560		2
3	Housekeeping	53,941	27,815		81,756		81,756	38	81,794		3
4	Laundry	65,535	10,120		75,655		75,655		75,655		4
5	Heat and Other Utilities			76,005	76,005		76,005	1,371	77,376		5
6	Maintenance	63,079	31,560	56,143	150,782		150,782	16,155	166,937		6
7	Other (specify):*										7
8	TOTAL General Services	368,262	262,167	132,148	762,577		762,577	22,876	785,453		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,761,512	95,039	8,917	1,865,468		1,865,468	(10,792)	1,854,676		10
10a	Therapy		405,083	575,160	980,243	(441,736)	538,507		538,507		10a
11	Activities	67,618	3,281		70,899		70,899		70,899		11
12	Social Services	37,449		3,723	41,172		41,172		41,172		12
13	CNA Training							940	940		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,866,579	503,403	597,400	2,967,382	(441,736)	2,525,646	(9,852)	2,515,794		16
	C. General Administration										
17	Administrative	82,400			82,400		82,400		82,400		17
18	Directors Fees										18
19	Professional Services			228,767	228,767		228,767	(208,216)	20,551		19
20	Dues, Fees, Subscriptions & Promotions			83,968	83,968	(54,203)	29,765	(5,391)	24,374		20
21	Clerical & General Office Expenses	134,252	18,091	11,663	164,006		164,006	316,050	480,056		21
22	Employee Benefits & Payroll Taxes			542,431	542,431		542,431	47,196	589,627		22
23	Inservice Training & Education			6,370	6,370		6,370	854	7,224		23
24	Travel and Seminar			3,388	3,388		3,388	1,611	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,379	39,379		39,379	13,669	53,048		26
27	Other (specify):*			9,600	9,600		9,600	(9,600)			27
28	TOTAL General Administration	216,652	18,091	925,566	1,160,309	(54,203)	1,106,106	156,173	1,262,279		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,451,493	783,661	1,655,114	4,890,268	(495,939)	4,394,329	169,197	4,563,526		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 Mendota

#0048108

Report Period Beginning:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							113,695	113,695			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,310	33,310		33,310	64,362	97,672			32
33	Real Estate Taxes							50,379	50,379			33
34	Rent-Facility & Grounds			433,623	433,623		433,623	(428,795)	4,828			34
35	Rent-Equipment & Vehicles			10,777	10,777		10,777	7,885	18,662			35
36	Other (specify):*											36
37	TOTAL Ownership			477,710	477,710		477,710	(192,474)	285,236			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					441,736	441,736	(31,684)	410,052			39
40	Barber and Beauty Shops		718	8,109	8,827		8,827		8,827			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,203	54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		718	8,109	8,827	495,939	504,766	(31,684)	473,082			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,451,493	784,379	2,140,933	5,376,805		5,376,805	(54,961)	5,321,844			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 Mendota

0048108

Report Period Beginning: 01/01/15

Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(830)			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	(1,447)			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	(4,975)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,532)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,600)			24
25	Fund Raising, Advertising and Promotional	(12,708)			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)	\$ (34,092)		\$	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	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)	(20,869)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,869)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (54,961)		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

Heritage Health Mendota

ID# 0048108

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,532)	19	22
23				23
24		(9,600)	27	24
25		(12,708)	20	25
26				26
27		(830)	34	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		(27,670)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mendota# 0048108

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	5,281	0	0	0	0	0	0	0	0	5,281	1
2	Food Purchase	0	0	31	0	0	0	0	0	0	0	0	31	2
3	Housekeeping	0	0	38	0	0	0	0	0	0	0	0	38	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,371	0	0	0	0	0	0	0	0	1,371	5
6	Maintenance	0	0	16,155	0	0	0	0	0	0	0	0	16,155	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,876	0	0	0	0	0	0	0	0	22,876	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	(11,414)	622	0	0	0	0	0	0	0	0	(10,792)	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	940	0	0	0	0	0	0	0	0	940	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	(11,414)	1,562	0	0	0	0	0	0	0	0	(9,852)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,532)	(222,648)	18,964	0	0	0	0	0	0	0	0	(208,216)	19
20	Fees, Subscriptions & Promotions	(12,708)	0	7,317	0	0	0	0	0	0	0	0	(5,391)	20
21	Clerical & General Office Expenses	0	0	316,050	0	0	0	0	0	0	0	0	316,050	21
22	Employee Benefits & Payroll Taxes	0	0	47,196	0	0	0	0	0	0	0	0	47,196	22
23	Inservice Training & Education	0	(140)	994	0	0	0	0	0	0	0	0	854	23
24	Travel and Seminar	(4,975)	0	6,586	0	0	0	0	0	0	0	0	1,611	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	13,669	0	0	0	0	0	0	0	0	13,669	26
27	Other (specify):*	(9,600)	0	0	0	0	0	0	0	0	0	0	(9,600)	27
28	TOTAL General Administration	(31,815)	(222,788)	410,776	0	0	0	0	0	0	0	0	156,173	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,815)	(234,202)	435,214	0	0	0	0	0	0	0	0	169,197	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mendota

0048108

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	94,282	0	19,413	0	0	0	0	0	0	0	113,695	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,447)	65,870	0	(61)	0	0	0	0	0	0	0	64,362	32
33	Real Estate Taxes	0	50,379	0	0	0	0	0	0	0	0	0	50,379	33
34	Rent-Facility & Grounds	(830)	(433,623)	0	5,658	0	0	0	0	0	0	0	(428,795)	34
35	Rent-Equipment & Vehicles	0	0	0	7,885	0	0	0	0	0	0	0	7,885	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,277)	(223,092)	0	32,895	0	0	0	0	0	0	0	(192,474)	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	(31,684)	0	0	0	0	0	0	0	0	0	(31,684)	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	(31,684)	0	0	0	0	0	0	0	0	0	(31,684)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(34,092)	(488,978)	435,214	32,895	0	0	0	0	0	0	0	(54,961)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>10 Adjustment for Related Organiza</u>	\$	<u>GreenTree Pharmacy</u>	<u>0.00%</u>	\$ <u>(11,414)</u>	\$ <u>(11,414)</u>	1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(140)</u>	<u>(140)</u>	2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(31,684)</u>	<u>(31,684)</u>	3
4	V	<u>19 Adjustment for Related Organization</u>	<u>222,648</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(222,648)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>433,623</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(433,623)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>50,379</u>	<u>50,379</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>61,097</u>	<u>61,097</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>94,282</u>	<u>94,282</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 656,271			\$ 167,293	\$ * (488,978)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$	5,281	15	
16	V	2 Food Purchase						31	16	
17	V	3 Housekeeping						38	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						1,371	19	
20	V	6 Maintenance						16,155	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						622	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						940	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						18,964	31	
32	V	20 Fees, Subscription, Promotions						7,317	32	
33	V	21 Clerical & General Office Expenses						316,050	33	
34	V	22 Employee Benefits & Payroll Taxes						47,196	34	
35	V	23 Inservice Training & Education						994	35	
36	V	24 Travel and Seminar						6,586	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						13,669	38	
39	Total		\$			\$	0	\$ *	435,214	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$	\$	0	15	
16	V	30 Depreciation						19,413	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(61)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						5,658	20	
21	V	35 Rent-Equipment & Vehicles						7,885	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	\$ *	32,895	39

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

Facility Name & ID Number Heritage Health Mendota # 0048108 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Heritage Health Mendota

0048108

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,835	27	\$ 151,240	\$ 150,308	99	\$ 5,281	1
2	2	Food Purchase	Beds	2,835	27	878	0	99	31	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	99	38	3
4	4	Laundry	Beds	2,835	27	0	0	99	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	99	1,371	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	99	16,155	6
7	7	Other	Beds	2,835	27	0	0	99	0	7
8	9	Medical Director	Beds	2,835	27	0	0	99	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	99	622	9
10	11	Activities	Beds	2,835	27	0	0	99	0	10
11	12	Social Service	Beds	2,835	27	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	99	940	12
13	14	Program Transportation	Beds	2,835	27	0	0	99	0	13
14	15	Other	Beds	2,835	27	0	0	99	0	14
15	17	Administrative	Beds	2,835	27	0	0	99	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	99	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	99	18,964	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	99	7,317	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	99	316,050	19
20	22	Employee Benefits & Payroll Tax	Beds	2,835	27	1,351,528	0	99	47,196	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	99	994	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	99	6,586	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0	99	13,669	24
25	TOTALS					\$ 12,462,987	\$ 8,837,683		\$ 435,214	25

Facility Name & ID Number Heritage Health Mendota

0048108

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization See Pg 8
 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	27	Other	Beds	2,835	27	\$	99	\$	1
2	30	Depreciation	Beds	2,835	27	555,915	99	19,413	2
3	31	Amortization of Pre-Op & Org	Beds	2,835	27		99		3
4	32	Interest	Beds	2,835	27	(1,746)	99	(61)	4
5	33	Real Estate Taxes	Beds	2,835	27		99		5
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022	99	5,658	6
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798	99	7,885	7
8	36	Other	Beds	2,835	27		99		8
9	38	Medically Nec Transportation	Beds	2,835	27		99		9
10	39	Ancillary Service Centers	Beds	2,835	27		99		10
11	40	Barber and Beauty Shops	Beds	2,835	27		99		11
12	41	Coffee and Gift Shops	Beds	2,835	27		99		12
13	42	Other	Beds	2,835	27		99		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	\$		\$ 32,895	25

Facility Name & ID Number

Heritage Health Mendota

0048108

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bank of America		x	Mortgage			\$	\$			\$ 61,097						
2	Bank of America		x	Loan Fee Amortization							4,773						
3																	
4																	
5																	
Working Capital																	
6	Bank of America		x	Working Capital							33,310						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 99,180						
B. Non-Facility Related*																	
10	Interest Income										(1,447)						
11																	
12	Allocated Corporate										(61)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,508)						
15	TOTALS (line 9+line14)						\$	\$			\$ 97,672						

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 2014 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.)		\$	50,379		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	50,379		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.		\$	50,379		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	_____	8	FOR BHF USE ONLY		
	2011	46,327	9			
	2012	46,607	10			
	2013	48,223	11			
	2014	50,379	12			
				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 Mendota COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 48108

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>01-34-100-020</u>	_____	\$ <u>50,378.58</u>	\$ <u>50,378.58</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>50,378.58</u></u>	\$ <u><u>50,378.58</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Heritage Health Mendota

0048108 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,580 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>26,150</u>	1
2					2
3	TOTALS			\$ <u>26,150</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	99			\$ 697,500	\$		\$	\$
5				408,657				
6								
7								
8								
Improvement Type**								
9	1980 Improvements	1980		8,150				
10	1981 Improvements	1981		20,492				
11	1982 Improvements	1982		9,185				
12	1983 Improvements	1983		5,682				
13	1984 Improvements	1984		11,488				
14	1985 Improvements	1985		7,710				
15	1986 Improvements	1986		2,255				
16	1987 Improvements	1987		9,037				
17	1988 Improvements	1988		21,297				
18	1989 Improvements	1989		4,653				
19	1990 Improvements	1990		36,595				
20	1991 Improvements	1991						
21	1992 Improvements	1992		10,646				
22	1993 Improvements	1993		62,261				
23	1994 Improvements	1994		10,869				
24	1995 Improvements	1995		18,523				
25	Exterior Door	1996		2,563				
26	Shower Tile	1996		806				
27	Kitchen Heat/Cool Unit	1996		14,062				
28	Resident Room Painting	1996		2,067				
29								
30								
31								
32								
33	C/O Allocation				19,413		19,413	
34	Book Depreciation				71,293		71,293	
35								
36								

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	Garbage Disposal	1997	\$ 2,030	\$		\$	\$	\$	37
38	Generator	1997	39,380						38
39	Parking Lot Asphalt	1997	2,210						39
40	Shower	1997	701						40
41									41
42	Kitchen Drain	1998	3,245						42
43	Walk in Cooler Repair	1998	2,215						43
44	A/C Unit	1998	1,615						44
45	Landscaping	1998	4,696						45
46									46
47	Door Alarm System	1999	11,750						47
48	Air Conditioning Condensing Unit	1999	1,027						48
49	Water Softener	1999	4,493						49
50									50
51	Air conditioner (3)	2000	2,221						51
52	Sprinklers	2000	1,864						52
53	Resident Room Doors (45)	2000	1,724						53
54	Facility Remodel -- Materials	2000	410,365						54
55	Facility Remodel -- Labor	2000	4,030						55
56	Facility Remodel -- Professional Fees	2000	23,932						56
57	Facility Remodel -- Interior Design	2000	36,998						57
58	Water Softener	2000	4,713						58
59									59
60	Parking Spaces	2001	1,452						60
61	Water Heater	2001	2,847						61
62									62
63	Water Heater	2002	3,816						63
64	Wood door	2002	677						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,932,499	\$ 90,706		\$ 90,706	\$	\$	70

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

Facility Name & ID Number Heritage Health Mendota

0048108

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,932,499	\$ 90,706		\$ 90,706	\$	\$	1
2	Furnace	2003	2,491						2
3	A/C Unit	2003	3,083						3
4	Condensing Unit	2003	1,353						4
5									5
6	Heat/Cool Unit	2004	2,498						6
7	Disposal	2004	989						7
8	Garage Repairs	2004	4,866						8
9	Compressor	2004	1,805						9
10	Emergency Outlets	2004	1,565						10
11	Furnace	2004	6,280						11
12									12
13	Exterior Door	2005	3,161						13
14	Holding Tank	2005	3,897						14
15	Smoke Detector	2005	1,919						15
16	A/C Unit	2005	4,248						16
17	Parking Lot	2005	68,313						17
18	Dumpster Pad	2005	1,547						18
19	Sidewalks	2005	7,850						19
20									20
21	Floor -- entry way	2006	19,178						21
22	Shower rehab	2006	6,246						22
23	Phone system	2006	1,836						23
24	A/C Unit	2006	2,201						24
25	Compressor	2006	1,642						25
26	Remodel TLC unit -- paint, wallpaper	2006	6,126						26
27	Parking Lot	2006	3,633						27
28	Roof	2006	148,938						28
29	Valance	2006	581						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,238,745	\$ 90,706		\$ 90,706	\$	\$	34

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

Facility Name & ID Number Heritage Health Mendota

0048108

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,238,745	\$ 90,706		\$ 90,706	\$	\$	1
2									2
3	Metal Roof	2007	49,988						3
4	Door Alarm	2007	2,986						4
5	HVAC	2007	3,370						5
6	Sprinkler system	2007	101,380						6
7	Wander Alarm	2007	8,092						7
8	fire Alarm	2007	42,223						8
9	Water Heater	2007	3,820						9
10	Grab Bars	2007	4,193						10
11									11
12	Heat/Cool Units	2008	2,713						12
13									13
14	Water Heater	2009	6,340						14
15	Sidewalks	2009	35,988						15
16	Furnace	2009	4,190						16
17									17
18	Shower Room Tile	2010	20,608						18
19	Landscaping	2010	6,702						19
20									20
21									21
22	Furnace	2011	3,513						22
23									23
24	Physical Therapy Room -- Replace Flooring	2012	7,887						24
25	Lighting Upgrade	2012	2,699						25
26	Cpmpressor	2012	3,588						26
27									27
28	WiFi Cabling	2013	7,382						28
29	Air Units	2013	2,582						29
30	Storage Tank Installation	2013	5,830						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,564,819	\$ 90,706		\$ 90,706	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,564,819	\$ 90,706		\$ 90,706	\$	\$	1
2									2
3	Install Ductless Split System-Server Room	2014	5,420						3
4	Install 6 "Thru Wall" AC Units	2014	3,815						4
5	Boiler Replacement	2014	6,100						5
6	Parking Lot Fill, Seal and Stripe	2014	4,910						6
7									7
8	Installed (5) PTAC units	2015	3,321						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,588,385	\$ 90,706		\$ 90,706	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 981,308	\$ 22,989	\$ 22,989	\$		\$	71
72	Current Year Purchases	16,446						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 997,754	\$ 22,989	\$ 22,989	\$		\$	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)	\$ 3,612,289	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 113,695	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,695	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 Mendota

0048108

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 10,777 Description: Televisions and copiers

(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 Mendota # 0048108 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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 245,326	\$		\$ 245,326	1
2	Licensed Speech and Language Development Therapist		hrs			29,115			29,115	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			263,804	262		264,066	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				404,821		404,821	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					36,915			36,915	13
14	TOTAL			\$		\$ 575,160	\$ 405,083		\$ 980,243	14

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

Facility Name & ID Number Heritage Health Mendota# 0048108Report 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 656	\$	1
2	Cash-Patient Deposits	15,931		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	904,497		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,677		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,754,544)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (795,783)	\$	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)	\$ (795,783)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 264,414	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,931		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,260		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,665		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	21,093		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 486,363	\$	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)	\$ 486,363	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,282,146)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (795,783)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,078,995)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,078,995)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(203,151)	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)	\$ (203,151)	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)	\$ (1,282,146)	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 4,309,397	1	
2	Discounts and Allowances for all Levels	(1,781,007)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,528,390	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,872,940	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,872,940	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	11,333	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space	830	16	
17	Sale of Drugs	758,714	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)	\$ 770,877	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	1,447	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,447	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)	\$ 5,173,654	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	762,577	31	
32	Health Care	2,967,382	32	
33	General Administration	1,160,309	33	
B. Capital Expense				
34	Ownership	477,710	34	
C. Ancillary Expense				
35	Special Cost Centers	8,827	35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,376,805	40	
41	Income before Income Taxes (line 30 minus line 40)**	(203,151)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (203,151)	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 Mendota

0048108

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,778	1,872	\$ 67,555	\$ 36.09	1
2	Assistant Director of Nursing	1,839	1,936	62,492	32.28	2
3	Registered Nurses	10,937	11,513	387,998	33.70	3
4	Licensed Practical Nurses	12,697	13,365	354,558	26.53	4
5	CNAs & Orderlies	57,598	60,629	888,909	14.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,736	4,985	67,618	13.56	10
11	Social Service Workers	1,696	1,785	37,449	20.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,480	16,295	185,707	11.40	15
16	Dishwashers					16
17	Maintenance Workers	3,247	3,418	63,079	18.45	17
18	Housekeepers	4,484	4,720	53,941	11.43	18
19	Laundry	5,320	5,600	65,535	11.70	19
20	Administrator	1,976	2,080	82,400	39.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,847	6,155	134,252	21.81	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)	127,635	134,353	\$ 2,451,493 *	\$ 18.25	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	9,600		36
37	Medical Records Consultant	4,616		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,301		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	3,723		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,240		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. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function				Description	Amount	Description	Amount				
Lynn Klein			\$ 82,400	Workers' Compensation Insurance	\$ 45,528	IDPH License Fee	\$					
				Unemployment Compensation Insurance	28,788	Advertising: Employee Recruitment		6,773				
				FICA Taxes	187,539	Health Care Worker Background Check (Indicate # of checks performed)		1,312				
				Employee Health Insurance	266,435	Patient Background Checks						
				Employee Meals		PR		3,283				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions		8,255				
						License & Fees		4,897				
				Other Benefits	14,141	Central Office Allocation		7,317				
				Central Office Allocation	47,196	Less: Public Relations Expense		(3,283)				
						Non-allowable advertising		(4,180)				
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 82,400	TOTAL (agree to Schedule V, line 22, col.8)			\$ 589,627	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,374	
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description				Amount	Description	Line #	Amount	Description	Amount			
				\$			\$	Out-of-State Travel	\$			
								In-State Travel				
									3,291			
									97			
								Seminar Expense	0			
								Central Office Allocation	1,611			
								Entertainment Expense	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)			\$ 4,999
C. Professional Services												
Vendor/Payee	Type		Amount									
Heritage Operations Group	Mgt		\$ 222,743									
ADP	Payroll Tax Processing		982									
Consova	HR Consulting		658									
Legal adj to Zero			4,384									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 228,767								

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Heritage Health Mendota

0048108

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. \$ 54,203
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. \$ 779
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None claimed
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH		656			1,009	1,009 PETTY C 656
1010	CASH IN BANK					1,100	1,100 ACCTS R 968,555
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. (64,058)
1100	ACCOUNTS RECEIVABLE	904,497				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 37,677
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	37,677				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 0
1409	LAND	0				1,460	0
1450	FURNITURE & EQUIPMENT	0				1,475	1,475 CODE AI 0
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM] 0
1475	BUILDING & IMPROVEMEN	0				1,530	1,530 RESIDEN 15,931
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	15,931				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (1,754,544)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (264,414)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-1,754,544				2,100	2,100 ACCRUE (32,782)
2010	ACCOUNTS PAYABLE	-264,414				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-32,782				2,110	2,110 ACCRUE (148,478)
2110	ACCRUED VACATION PAY	-148,478				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(3,665)	
2125	FICA TAX PAYABLE	-3,665	-3,665	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REF		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETE		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(21,093)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-21,093		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO 1	(15,931)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	0	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	1,078,995	
2460	INCOME TAXES PAYABLE				net income	203,151	
2512	DUE TO RESIDENTS	-15,931					
2600	MORTGAGE PAYABLE	0					
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>	
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	1,078,995					
2970	PROFIT/LOSS FOR PERIOD	203,151					
3007.1	PATIENT DAYS-PRIVATE	9,928					3,007

3007.2	PATIENT DAYS-IPA	13,356						3,007
3007.3	PATIENT DAYS-MEDICARE	365						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-4,275,262	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-31,268	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	-758,714	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,872,940	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	1,781,007	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	-830		6	0	6	-830		3,530
3530	13 BEAUTY SHOP	-11,333		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-2,867		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	124,608	134,252	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	82,400	82,400	17	1	0	0		4,120
4115	VACATION & SICK - G&A	9,644		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	14,106	542,431	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	35		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	18,091	18,091	21	2	0	0		4,275
4260	TELEPHONE	11,663	11,663	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	6,370	6,370	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	3,291	3,388	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	97		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	0		24	3	19	-4,975 ***		4,289
4290	HELP WANTED ADVERTISING	6,773	83,968	20	3	0	0 -54,203		4,290
4291	PROMOTIONAL ADVERTISING	5,245		20	3	25	-5,245		4,291
4292	PUBLIC RELATIONS	3,283		20	3	25	-3,283		4,292
4300	LICENSES & FEES	59,100		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	8,255		20	3	17	-4,180		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	6,119	228,767	19	3	22	-4,532		4,350
4355	MEDICAL DIRECTOR	9,600	9,600	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	4,616		10	3	0	0	4,364
4363	PHARMACIST FEES	4,301		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,723	3,723	12	3	0	0	4,383
4370	TV RENTAL	8,408		35	3	5	0	4,390
4380	INCOME TAXES		9,600	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,312		20	3	26	0	4,401
4400	PAYROLL TAXES	207,774		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,553		22	3	0	0	4,420
4410	GROUP INSURANCE	266,435		22	3	0	0	4,430
4420	LIABILITY INSURANCE	39,379	39,379	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	45,528		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	222,648		19	3	34	0 **	4,460
4460	BAD DEBTS	9,600		27	3	24	-9,600	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	2,369	10,777	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	57,053	63,079	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	6,026		6	1	0	0	4,510
5130	ELECTRIC	43,037	76,005	5	3	0	0	4,600
5131	NATURAL GAS	10,007		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	22,961		5	3	0	0	5,130
5134	TRASH COLLECTION	15,166	56,143	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	4,040	31,560	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	27,520		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	40,977		6	3	0	0	5,140
5210	DIETARY WAGES	174,334	185,707	1	1	0	0	5,160
5220	DIETARY SICK & VAC	11,373		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	179,308	178,529	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,562	14,143	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,998		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,583		1	2	0	0	5,260
5295	MEAL CREDIT	-779		2	2	0	0	5,270
5310	LAUNDRY WAGES	59,983	65,535	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	5,552		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	6,019	10,120	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	4,101		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	50,717	53,941	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	3,224		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	27,815	27,815	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	0		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,761,512	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	342,043		10	1	0	0	6,020
6030	DON WAGES	67,555		10	1	0	0	6,030
6035	ADON	62,492		10	1	0	0	6,035
6040	RN SICK & VACATION	45,955		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	329,705		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	24,853		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	833,224		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	55,685		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	20,046	95,039	10	2	0	0	7,281
6295	NURSING SUPPLIES	71,040		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	3,953		10	2	0	0	7,391
6490	NURSING OTHER	0	8,917	10	3	0	0	7,393
7280	DRUG PURCHASES	139,259	405,083	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	265,562		39	2			7,540
7380	LABORATORY SERVICES	36,915	575,160	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	62,617	67,618	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,001		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	3,281	3,281	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	263,804		39	3	0	0 ***	7,890
7660	PT SUPPLIES	262		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	33,719	37,449	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	3,730		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	245,326		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	29,115		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	8,109	8,109	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	718	718	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	433,623	433,623	34	3	0	0	

8120	INTEREST EXPENSE	33,310	33,310	32	3	14	-1,447	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-1,447		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		5,375,358	5,376,805					
			1,447					

GRAND TOTALS

203,151	-34,092
(NET INCOME)	

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP	9,928	9,928
IPA	13,356	13,356
medicare	365	365
		23,649

UND

RIA

BT

BT

3,007 PATIENT 13,356
3,007 PATIENT 365
0

3,010 BASIC CI (4,275,262)

3,020 BASIC CI 0

3,030 BASIC CI 0

0

0

0

0

3,080 NURSING (31,268)

3,081 NURSING SUPPLIES-IPA

3,082 NURSING SUPPLIES-M/C A

3,083 NURSING 0

3,100 DRUGS-M (758,714)

3,110 PHYSICIAN (1,872,940)

0

3,112 PHYSICIAN 0

3,113 PHYSICIAN 0

3,140 LABORATORY INCOME

0

3,152 ST/OT TF 0

3,153 ST/OT TF 0

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER 0

3,411 MEDICAL 0

3,420 MEDICAL 1,714,444

3,520 RENT INC	(830)
3,530 BEAUTY	(11,333)
3,570 VENDING	0
3,590 EQUIPMI	(2,867)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	124,608
4,111 ADMINIS	82,400
4,115 G&A PTC	9,644
4,120 EMPLOY	13,160
4,130 EMPLOY	0
4,135 EMPLOY	35
4,250 OFFICE S	7,322
4,255 POSTAGI	1,413
4,260 TELEPHC	11,663
4,275 TRAININ	6,370
	0
4,280 GENERA	3,291
4,281 MEAL EX	97
4,285 EDUCATION/SEMINARS	
4,289 MEETINGS EXPENSE	
4,290 HELP WA	6,773
4,291 PROMOT	5,245
4,292 PUBLIC I	3,283
4,300 LICENSE	59,100
4,310 DUES & :	8,255
4,320 CONTRIBUTIONS	
4,350 PROFESS	6,119
4,355 MEDICAL	9,600
	4,616
	4,301

4,364 SOCIAL S	3,723
4,370 TV RENT	8,408
4,383 BACKGR	1,312
4,390 OTHER T	0
4,400 PAYROL	207,774
4,401 PAYROL	8,553
4,410 GROUP I	266,435
4,420 LIABILIT	39,379
4,430 WORKM.	45,248
4,435 W/C-FIRS	(482)
4,436 DRUG TE	762
4,450 MANAGI	222,648
4,460 BAD DEF	9,600
4,461 BAD DEF	66,563
4,470 LOST ITE	0
4,475 UNIFORM	946
4,486 SERVICE	20,904
4,490 MISC EX	361
4,496 MISC. M.	9,356
4,510 REAL ES	0
4,600 LEASED	2,369
5,110 MAINTEN	57,053
5,120 MAINTEN	6,026
5,130 ELECTRI	43,037
5,131 NATURA	10,007
5,133 WATER &	22,961
5,134 TRASH C	15,166
5,140 PROP/PL	4,040
5,160 GENERA	27,520
5,165 MAINTEN	20,073
5,210 DIETARY	174,334
5,220 DIETARY	11,373
5,248 FOOD PU	178,947

5,250 SUPPLIE	2,562
5,260 REPLACI	3,998
5,270 KITCHEN	7,583
5,295 MEAL IN	(779)
5,310 LAUNDR	59,983
5,340 LAUNDR	5,552
5,370 REPLACI	6,019
5,390 SUPPLIE	4,101
5,410 HOUSEK	50,717
5,440 HOUSEK	3,224
5,480 SUPPLIE	27,815
5,490 SUPPLIES-HOUSEKEEPING	
6,020 RN WAG	342,043
6,030 DON WA	67,555
6,035 ADON W	62,492
6,040 RN PTO &	45,955
6,120 LPN WAG	329,705
6,140 LPN PTO	24,853
6,220 AIDES W	833,224
6,240 AIDES PT	55,685
6,245	
	0
	0
	0
6,270 REHAB WAGES	
6,275 REHAB PTO & RESERVE	
6,290 NURSINC	20,046
6,295 NURSINC	71,040
6,390 REPLACI	3,953
6,490 OTHER	

7,280 DRUG PU	139,259
7,281 DRUG PU	265,562
7,380 LABORA	21,335
7,390 X-RAY S	8,159
	7,421
7,510 ACTIVIT	62,617
7,540 ACTIVIT	5,001
7,590 ACTIVIT	3,281
7,620 PHYSICA	263,804
7,660 P.T. SUPE	262
7,710 SOCIAL S	33,719
7,720 SOCIAL S	3,730
7,730 SOCIAL S	0
7,740 OCCUPA	245,326
7,770 SPEECH'	29,115
7,820 BEAUTIC	8,109
	718
	0
8,120 INTERES	0
	33,310
8,130 DEPRECI	0
	0
9,510 INTERES	(1,447)
9,520 MISC NO	0
4,220	0
8,100	433,623
9,702	0
5,230	0
	<u>203,151</u>

Expenses Fixed Assets

