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.

I. IDPH License ID Number: 0050724

Facility Name: St Claras Manor

Address: 200 Fifth Street (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

Telephone Number: 217-735-1507 **Fax #** 217-732-3188

HFS ID Number:

Date of Initial License for Current Owners: 2010

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501			Corporation		Other
			"Sub-S" Corp.		
			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 St Claras Manor # 0050724 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	140	Skilled (SNF)	140	51,100	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	140	TOTALS	140	51,100	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	20,365	8,750	2,662	31,777	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,365	8,750	2,662	31,777	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.19%

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 2010

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 2,662

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 St Claras Manor # 0050724 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	280,273	20,675		300,948		300,948		300,948			1
2	Food Purchase		258,120		258,120		258,120		258,120			2
3	Housekeeping	141,606	25,539		167,145		167,145		167,145			3
4	Laundry	58,356	14,649		73,005		73,005		73,005			4
5	Heat and Other Utilities			98,413	98,413		98,413		98,413			5
6	Maintenance	46,454	73,846	78,949	199,249		199,249		199,249			6
7	Other (specify):*											7
8	**TOTAL General Services**	526,689	392,829	177,362	1,096,880		1,096,880		1,096,880			8
	B. Health Care and Programs											
9	Medical Director			19,499	19,499		19,499		19,499			9
10	Nursing and Medical Records	1,741,634	210,397	220,168	2,172,199		2,172,199		2,172,199			10
10a	Therapy		166,132	579,638	745,770	(195,647)	550,123		550,123			10a
11	Activities	59,285	6,047		65,332		65,332		65,332			11
12	Social Services	42,594		3,252	45,846		45,846		45,846			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,843,513	382,576	822,557	3,048,646	(195,647)	2,852,999		2,852,999			16
	C. General Administration											
17	Administrative	76,708			76,708		76,708		76,708			17
18	Directors Fees											18
19	Professional Services			254,074	254,074		254,074	(6,062)	248,012			19
20	Dues, Fees, Subscriptions & Promotions			124,263	124,263	(76,650)	47,613	(25,725)	21,888			20
21	Clerical & General Office Expenses	153,253	18,627	6,922	178,802		178,802		178,802			21
22	Employee Benefits & Payroll Taxes			754,292	754,292		754,292		754,292			22
23	Inservice Training & Education			5,456	5,456		5,456		5,456			23
24	Travel and Seminar			3,748	3,748		3,748		3,748			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,430	77,430		77,430		77,430			26
27	Other (specify):* **Lost resident items**			53,300	53,300		53,300	(53,000)	300			27
28	**TOTAL General Administration**	229,961	18,627	1,279,485	1,528,073	(76,650)	1,451,423	(84,787)	1,366,636			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,600,163	794,032	2,279,404	5,673,599	(272,297)	5,401,302	(84,787)	5,316,515			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 St Claras Manor #0050724 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							83,430	83,430			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(7,847)	(7,847)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			459,900	459,900		459,900	(459,900)				34
35	Rent-Equipment & Vehicles			1,990	1,990		1,990		1,990			35
36	Other (specify):*											36
37	**TOTAL Ownership**			461,890	461,890		461,890	(384,317)	77,573			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					195,647	195,647		195,647			39
40	Barber and Beauty Shops			13,977	13,977		13,977		13,977			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					76,650	76,650		76,650			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			13,977	13,977	272,297	286,274		286,274			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,600,163	794,032	2,755,271	6,149,466		6,149,466	(469,104)	5,680,362			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 St Claras Manor # 0050724 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	(7,847)			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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,062)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,000)			24
25	Fund Raising, Advertising and Promotional	(25,725)			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)**	$ (92,634)		$	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)	(376,470)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (376,470)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (469,104)		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

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St Claras Manor

ID# 0050724

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		(6,062)	19	22
23				23
24		(53,000)	27	24
25		(25,725)	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**	(84,787)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Claras Manor # 0050724 **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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,062)	0	0	0	0	0	0	0	0	0	0	(6,062)	19
20	Fees, Subscriptions & Promotions	(25,725)	0	0	0	0	0	0	0	0	0	0	(25,725)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(53,000)	0	0	0	0	0	0	0	0	0	0	(53,000)	27
28	**TOTAL General Administration**	(84,787)	0	0	0	0	0	0	0	0	0	0	(84,787)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,787)	0	0	0	0	0	0	0	0	0	0	(84,787)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Claras Manor **#** 0050724 **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	83,430	0	0	0	0	0	0	0	0	0	83,430	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,847)	0	0	0	0	0	0	0	0	0	0	(7,847)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(459,900)	0	0	0	0	0	0	0	0	0	(459,900)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,847)	(376,470)	0	0	0	0	0	0	0	0	0	(384,317)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(92,634)	(376,470)	0	0	0	0	0	0	0	0	0	(469,104)	45

Facility Name & ID Number St Claras Manor # 0050724 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
NFP-BOD List Attached				St Clara's Senior Servi	Lincoln	Sponsor Org

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			$			$	$	1
2	V	34	Adjustment for Related Organization	459,900				(459,900)	2
3	V	30			St Clara's Senior Services Inc.	0.00%	83,430	83,430	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 459,900			$ 83,430	$ * (376,470)	14

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

Facility Name & ID Number St Claras Manor # 0050724 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number St Claras Manor # 0050724 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	None								$		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 St Claras Manor # 0050724 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 [x]

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

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

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

Facility Name & ID Number St Claras Manor # 0050724 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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10	**Interest Income**										(7,847)	10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$ (7,847)	14
15	**TOTALS (line 9+line14)**						$	$			$ (7,847)	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 St Claras Manor # 0050724 **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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		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 St Claras Manor COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0050724

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 St Claras Manor # 0050724 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,286 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number St Claras Manor # 0050724 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	140				$ 1,624,882	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976			1976	65,361						9
10	1978			1978	3,451						10
11	1980			1980	8,793						11
12	1981			1981	11,439						12
13	1982			1982	3,826						13
14	1983			1983	1,535						14
15	1984			1984	4,031						15
16	1985			1985	7,859						16
17	1986			1986	2,541						17
18	1987			1987	10,753						18
19	1988			1988	1,006						19
20	1989			1989	1,431						20
21	1991			1991	8,799						21
22	1992			1992	17,963						22
23	1993			1993	15,564						23
24	1994			1994	51,022						24
25	1995			1995	124,932						25
26	1996			1996	102,380						26
27	1997			1997	39,247						27
28	Fire Sprinkler			1998	22,151						28
29	Transfer Switch			1998	4,819						29
30	Water Line			1998	6,379						30
31	Soffits			1998	3,950						31
32	Generator			1998	3,164						32
33	Heating, A/C Improvements			1998	8,664						33
34											34
35	Depreciation					61,270		61,270			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 St Claras Manor # 0050724 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	Windows	1998	$ 3,422	$		$	$	$	37
38	Sidewalks	1998	2,963						38
39	Fixtures	1999	224						39
40	Faucets	1999	1,532						40
41	Water System Improvements	1999	7,920						41
42	Windows	1999	23,400						42
43	Fixtures	1999	2,812						43
44	Faucets	1999	1,404						44
45	Heating & Cooling Unit	2000	4,050						45
46	Water System	2000	37,203						46
47	Glass Doors	2000	1,145						47
48	Remodeling	2000	4,581						48
49	Plumbing	2000	4,128						49
50	Windows	2000	600						50
51	Plumbing	2000	1,702						51
52	4 Ton Condensing Unit	2000	4,453						52
53	Windows	2000	5,400						53
54	Exhaust Fan	2000	1,100						54
55	Heating & Cooling Units	2000	4,050						55
56	Doors	2000	4,081						56
57	Porch Ceiling	2000	4,050						57
58	Exhaust Fan	2000	2,046						58
59	Concrete Pad	2000	5,398						59
60	Fire Sprinkler	2001	1,304						60
61	Faucets	2001	3,432						61
62	Patio Roof	2001	1,532						62
63	Exhaust Fan	2001	1,000						63
64	A/C Unit	2001	16,312						64
65	A/C Kitchen	2001	6,850						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,314,036	$ 61,270		$ 61,270	$	$	70

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

Facility Name & ID Number St Claras Manor # 0050724 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		$ 2,314,036	$ 61,270		$ 61,270	$	$	1
2									2
3	Code Alert Alarm	2002	5,600						3
4	Ceiling Fan	2002	996						4
5	Heat Cool Units	2002	4,550						5
6	Carpet	2002	2,361						6
7	Seal Coat Parking Lot	2002	3,342						7
8	Walk-In Cooler	2002	17,518						8
9	Roof Replacement	2002	92,577						9
10	Door	2002	824						10
11	Wide Area Network Wiring	2002	3,167						11
12									12
13	Roof Replacement	2003	53,524						13
14	Facility Wiring	2003	11,041						14
15	Remodel Bathrooms	2003	33,616						15
16	Closet Doors	2003	4,188						16
17	Water Heaters and Storage Tank	2003	38,929						17
18	Capital Report Adj	2003	(10,796)						18
19	Furnace	2004	1,800						19
20	Remodel Activity room-- carpet	2004	2,624						20
21	Heat Cool Units	2004	8,094						21
22	Remodel Employee Lounge	2004	2,955						22
23	Electric Door opener	2004	1,598						23
24	Drain Grate	2004	2,350						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)		$ 2,594,894	$ 61,270		$ 61,270	$	$	34

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

Facility Name & ID Number St Claras Manor # 0050724 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		$ 2,594,894	$ 61,270		$ 61,270	$	$	1
2									2
3	Code Alert System	2005	726						3
4	Kitchen Hood	2005	1,662						4
5	Wander System	2005	2,543						5
6	Hallway remode -- Paint and carpet	2005	20,919						6
7	A/C Units	2005	1,187						7
8	Fire Supression	2005	1,845						8
9									9
10	A/C Units	2006	1,843						10
11	Security Camera	2006	1,059						11
12	PTAC Units	2006	1,287						12
13	A/C Units	2006	1,207						13
14									14
15									15
16									16
17	Simplex Fire Alarm	2008	8,105						17
18									18
19	Otis elevator	2008	183,160						19
20	Fire Alarm	2008	18,587						20
21									21
22	Fire Sprinkler	2009	4,477						22
23									23
24	Masonry --building exterior	2010	11,260						24
25									25
26	Water heater & conditioner	2011	19,115						26
27	Roof	2011	88,421						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,962,297	$ 61,270		$ 61,270	$	$	34

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

Facility Name & ID Number St Claras Manor # 0050724 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 12C, Carried Forward		$ 2,962,297	$ 61,270		$ 61,270	$	$	1
2									2
3	Rooftop Heating & Cooling Unit	2013	21,000						3
4	Lighting Retrofit	2013	4,482						4
5	Water Temperature Control & Mixing Valve	2013	4,370						5
6	A/C Unit	2013	2,540						6
7	Sprinkler Installation-Exterior Canopies	2013	5,580						7
8									8
9	New Generator	2014	43,875						9
10	Installation of Electrical Outlets	2014	4,432						10
11	Replace Condensing Unit	2014	4,528						11
12	Upgrade Tankless Water Heater	2014	26,198						12
13									13
14	Hot water boiler for laundry room	2015	5,680						14
15	PTAC installation	2015	2,563						15
16	Replace HVAC pump	2015	3,393						16
17	Install new hot water tank	2015	3,883						17
18	New 5 ton condensing unit	2015	3,300						18
19	Improve parking lot - sealcoat & stripe	2015	7,500						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)		$ 3,105,621	$ 61,270		$ 61,270	$	$	34

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

Facility Name & ID Number St Claras Manor # 0050724 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	$ 1,271,557	$ 21,381	$ 21,381	$		$	71
72	Current Year Purchases	(32,876)						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,238,681	$ 21,381	$ 21,381	$		$	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		2015 Grand Caravan	2015	$ 32,723	$ 779	$ 779	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 32,723	$ 779	$ 779	$		$	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)	$ 4,377,025	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,430	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,430	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 St Claras Manor # 0050724 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: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Claras Manor # 0050724 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 St Claras Manor # 0050724 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		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	$		$ 210,959	$		$ 210,959	1
2	Licensed Speech and Language Development Therapist		hrs			107,998			107,998	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			229,619	1,547		231,166	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				164,585		164,585	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					31,062			31,062	13
14	TOTAL			$		$ 579,638	$ 166,132		$ 745,770	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 St Claras Manor **#** 0050724 **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	$ 858,657	$	1
2	Cash-Patient Deposits	33,393		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	841,100		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,807		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	456,707		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,220,664	$	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)**	$ 2,220,664	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,376	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,393		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	168,103		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,441		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	28,899		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 363,212	$	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)**	$ 363,212	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,857,452	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,220,664	$	48

***(See instructions.)**

Facility Name & ID Number St Claras Manor **#** 0050724 **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**	$ 2,129,878	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,129,878	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(272,426)	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)**	$ (272,426)	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)**	$ 1,857,452	24 *

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

Facility Name & ID Number St Claras Manor # 0050724 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	$ 5,337,367	1
2	Discounts and Allowances for all Levels	(1,847,983)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,489,384	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,075,065	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,075,065	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	460	12
13	Barber and Beauty Care	16,037	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	279,792	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,455	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 302,744	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,847	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,847	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Contribution	2,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,877,040	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,096,880	31
32	Health Care	3,048,646	32
33	General Administration	1,528,073	33
	B. Capital Expense		
34	Ownership	461,890	34
	C. Ancillary Expense		
35	Special Cost Centers	13,977	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)***	$ 6,149,466	40
41	**Income before Income Taxes (line 30 minus line 40)****	(272,426)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (272,426)	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 St Claras Manor # 0050724 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	2,029	2,136	$ 69,551	$ 32.56	1
2	Assistant Director of Nursing	1,034	1,088	28,256	25.97	2
3	Registered Nurses	8,802	9,265	267,085	28.83	3
4	Licensed Practical Nurses	21,992	23,150	553,728	23.92	4
5	CNAs & Orderlies	56,123	59,077	759,620	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,237	2,355	63,394	26.92	8
9	Activity Director					9
10	Activity Assistants	5,218	5,493	59,285	10.79	10
11	Social Service Workers	1,836	1,933	42,594	22.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,353	26,687	280,273	10.50	15
16	Dishwashers					16
17	Maintenance Workers	3,307	3,481	46,454	13.35	17
18	Housekeepers	11,291	11,885	141,606	11.91	18
19	Laundry	5,010	5,274	58,356	11.06	19
20	Administrator	1,976	2,080	76,708	36.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,281	7,664	153,253	20.00	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)	153,489	161,568	$ 2,600,163 *	$ 16.09	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		19,499		36
37	Medical Records Consultant		1,805		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,923		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		3,252		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,479		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 St Claras Manor # 0050724 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Eads			$ 76,708
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,708

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 232,275
JM Abbott	Audit & Tax	14,531
ADP	Payroll Tax	956
AUL	Retirement Plan	250
Legal adj to Zero		6,062
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 254,074

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,914
Unemployment Compensation Insurance	6,815
FICA Taxes	198,912
Employee Health Insurance	425,286
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	36,365
TOTAL (agree to Schedule V, line 22, col.8)	$ 754,292

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	10,800
Health Care Worker Background Check	
(Indicate # of checks performed)	2,397
Patient Background Checks	
PR	4,411
Dues & Subscriptions	12,119
License & Fees	1,885
Less: Public Relations Expense	(4,411)
Non-allowable advertising	(5,313)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,888

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,528
	0
Seminar Expense	220
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,748

**See instructions.

Facility Name & ID Number St Claras Manor # 0050724 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 St Claras Manor # 0050724 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. $ **76,650**
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. $ **2,967**

(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: **JM Abbott**

(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	858,657					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	841,100					
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	30,807					
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	33,393					
1550	LOAN FEES	0					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	456,707					
2010	ACCOUNTS PAYABLE	-130,376					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	-33,979					
2110	ACCRUED VACATION PAY	-134,124					
1,009	1,009 CASH	858,657					
1,100	1,100 ACCTS R	1,031,767					
1,101	1,101 ALLOW.	(190,667)					
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	30,807					
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 BUILDIN	0					
1,490	1,490 ACCUM I	0					
1,530	1,530 RESIDEN	33,393					
1,550	1,550 LOAN FE	0					
1,551	1,551 LOAN FEES ADDED						
1,850	1,850 INTERCC	456,707					
2,010	2,010 ACCOUN	(130,376)					
2,100	2,095 BONUSES PAYABLE						
2,100	2,100 ACCRUE	(33,979)					
2,100	2,100 PR CLEARING-BENEFITS						
2,100	2,100 PR CLEARING-LABOR						
2,110	2,110 ACCRUE	(134,124)					
2,120	2,120 U.C. TAX	0					

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-2,441	-2,441
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	-28,899	
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	-33,393	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-2,129,878	
2970	PROFIT/LOSS FOR PERIOD	272,426	
3007.1	PATIENT DAYS-PRIVATE	8,750	

2,125	2,125	FICA TA	(2,441)
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	(28,899)
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	(33,393)
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	(2,129,878)
		net incom	272,426
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	20,365					3,007
3007.3		PATIENT DAYS-MEDICARE	2,662					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 &	-5,319,091	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	-17,662	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	-279,792	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-2,075,065	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	1,847,983	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	-16,037		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	-460		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-614		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	0		0	0	0	0			4,110
3600		21	MISC INCOME	-6,455		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	142,304	153,253	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	76,708	76,708	17	1	0	0			4,120
4115			VACATION & SICK - G&A	10,949		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	36,365	754,292	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	18,627	18,627	21	2	0	0			4,275
4260			TELEPHONE	6,922	6,922	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	5,456	5,456	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	3,528	3,748	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	0		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	220		24	3	19	0	***		4,289
4290			HELP WANTED ADVERTISI	10,800	124,263	20	3	0	0	-76,650		4,290
4291			PROMOTIONAL ADVERTIS	16,001		20	3	25	-16,001			4,291
4292			PUBLIC RELATIONS	4,411		20	3	25	-4,411			4,292
4300			LICENSES & FEES	78,535		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	12,119		20	3	17	-5,313			4,310
4320			CONTRIBUTIONS	0		27	3	20	0			4,320
4350			PROFESSIONAL FEES	21,778	254,074	19	3	22	-6,062			4,350
4355			MEDICAL DIRECTOR	19,499	19,499	9	3	0	0			4,355
4360			UTILIZATION REVIEW	0		10	3	0	0			4,362
4361			OTHER PHYSICIAN FEES			39	3	0	0			4,363

4362	MEDICAL RECORDS CONSI	1,805		10	3	0	0	4,364
4363	PHARMACIST FEES	5,923		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,252	3,252	12	3	0	0	4,383
4370	TV RENTAL	1,076		35	3	5	0	4,390
4380	INCOME TAXES		53,300	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,397		20	3	26	0	4,401
4400	PAYROLL TAXES	197,765		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	7,962		22	3	0	0	4,420
4410	GROUP INSURANCE	425,286		22	3	0	0	4,430
4420	LIABILITY INSURANCE	77,430	77,430	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	86,914		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	232,296		19	3	34	0 **	4,460
4460	BAD DEBTS	53,000		27	3	24	-53,000	4,461
4470	LOST ITEMS-RESIDENTS	300		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	914	1,990	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	44,522	46,454	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	1,932		6	1	0	0	4,510
5130	ELECTRIC	58,926	98,413	5	3	0	0	4,600
5131	NATURAL GAS	8,262		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	31,225		5	3	0	0	5,130
5134	TRASH COLLECTION	11,158	78,949	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	16,199	73,846	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	57,647		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	67,791		6	3	0	0	5,140
5210	DIETARY WAGES	266,265	280,273	1	1	0	0	5,160
5220	DIETARY SICK & VAC	14,008		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	261,087	258,120	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	7,134	20,675	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	6,473		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,068		1	2	0	0	5,260
5295	MEAL CREDIT	-2,967		2	2	0	0	5,270
5310	LAUNDRY WAGES	53,654	58,356	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,702		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	9,326	14,649	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,323		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	132,303	141,606	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	9,303		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	25,211	25,539	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	328		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,741,634	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	251,269		10	1	0	0	6,020
6030	DON WAGES	69,551		10	1	0	0	6,030
6035	ADON	28,256		10	1	0	0	6,035
6040	RN SICK & VACATION	15,816		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	524,199		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	29,529		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC	722,901		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	36,719		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	15,470		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	28,823		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	167,674		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WA	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	65	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	59,515		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,879		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	188,472	210,397	10	2	0	0	7,281
6295	NURSING SUPPLIES	1,775		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	20,150		10	2	0	0	7,391
6490	NURSING OTHER	408	220,168	10	3	0	0	7,393
7280	DRUG PURCHASES	164,585	166,132	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	0		39	2			7,540
7380	LABORATORY SERVICES	31,062	579,638	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	56,441	59,285	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	2,844		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	6,047	6,047	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	229,619		39	3	0	0 ***	7,890
7660	PT SUPPLIES	1,547		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	39,336	42,594	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	3,258		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	210,959		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	107,998		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	13,977	13,977	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	459,900	459,900	34	3	0	0	

8120	INTEREST EXPENSE	0	0	32	3	14	-7,847	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-7,847		32	0	10	0	
9520	MISC NON-OPERATING INC	-2,000		0	0	0	0	
9700	INCOME TAXES			0	0	0	0	
		6,139,619	6,149,466					
			9,847					
GRAND TOTALS		272,426					-92,634	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	8,750	8,750
IPA	20,365	20,365
medicare	2,662	2,662
		31,777

UND

RIA

BT

BT

3,007 PATIENT 8,750

3,007	PATIENT	20,365
3,007	PATIENT	2,662
		0
3,010	BASIC CI	(5,319,091)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSINC	(17,662)
3,081	NURSINC	0
3,082	NURSINC	0
3,083	NURSINC	0
3,100	DRUGS-N	(279,792)
		0
3,110	PHYSICA	(2,075,065)
		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	1,795,389

3,520	RENT IN(	0
3,530	BEAUTY	(16,037)
		0
3,570	VENDIN(	(460)
3,590	EQUIPMI	(614)
3,595	RESIDEN	0
3,600	MISC IN(	(6,455)
4,110	G&A WA	142,304
4,111	ADMINIS	76,708
4,115	G&A PT(	10,949
4,120	EMPLOY	36,349
4,130	EMPLOY	0
4,135	EMPLOY	0
4,250	OFFICE S	8,871
4,255	POSTAG	1,419
4,260	TELEPH(	6,922
4,275	TRAININ	5,456
		600
4,280	GENERA	3,528
4,281	MEAL E)	0
4,285	EDUCAT	145
4,289	MEETIN(	75
4,290	HELP W/	10,800
4,291	PROMOT	16,001
4,292	PUBLIC I	4,411
4,300	LICENSE	78,535
4,310	DUES & S	12,119
4,320	CONTRI	0
4,350	PROFESS	21,778
4,355	MEDICA	19,499
		1,805
		5,923

4,364	SOCIAL S	3,252
4,370	TV RENT	1,076
4,383	BACKGR	2,397
4,390	OTHER T	0
4,400	PAYROL	197,765
4,401	PAYROL	7,962
4,410	GROUP I	425,286
4,420	LIABILIT	77,430
4,430	WORKM	83,938
4,435	W/C-FIRS	904
4,436	DRUG TE	1,472
4,450	MANAGI	232,296
4,460	BAD DEI	53,000
4,461	BAD DEI	52,594
4,470	LOST ITI	300
4,475	UNIFORM	16
4,486	SERVICE	20,419
4,490	MISC EX	(209)
4,496	MISC. M.	8,337
4,510	REAL ES	0
4,600	LEASED	914
5,110	MAINTEI	44,522
5,120	MAINTEI	1,932
5,130	ELECTRI	58,926
5,131	NATURA	8,262
5,133	WATER &	31,225
5,134	TRASH C	11,158
5,140	PROP/PL	16,199
5,160	GENERA	57,647
5,165	MAINTEI	47,372
5,210	DIETARY	266,265
5,220	DIETARY	14,008
5,248	FOOD PU	261,296

5,250	SUPPLIE	7,134
5,260	REPLACI	6,473
5,270	KITCHEN	7,068
5,295	MEAL IN	(2,967)
5,310	LAUNDR	53,654
5,340	LAUNDR	4,702
5,370	REPLACI	9,326
		0
5,390	SUPPLIE	5,323
5,410	HOUSEK	132,303
5,440	HOUSEK	9,303
5,480	SUPPLIE	25,211
5,490	SUPPLIE	328
6,020	RN WAG	251,269
6,030	DON WA	69,551
6,035	ADON W	28,256
6,040	RN PTO &	15,816
6,120	LPN WAG	524,199
6,140	LPN PTO	29,529
6,220	AIDES W	722,901
6,240	AIDES PT	36,719
		15,470
		28,823
		167,674
		0
		65
		0
6,270	REHAB V	59,515
6,275	REHAB P	3,879
6,290	NURSING	188,472
6,295	NURSING	1,775
6,390	REPLACI	20,150
6,490	OTHER	408

7,280	DRUG PU	164,585
7,281	DRUG PURCHASES-OTHER	
7,380	LABORA	16,417
7,390	X-RAY S	8,675
		5,970
7,510	ACTIVIT	56,441
7,540	ACTIVIT	2,844
7,590	ACTIVIT	6,047
7,620	PHYSICA	229,619
7,660	P.T. SUPI	1,547
7,710	SOCIAL S	39,336
7,720	SOCIAL S	3,258
7,730	SOCIAL S	0
7,740	OCCUPA	210,959
7,770	SPEECH	107,998
7,820	BEAUTIC	13,977
		0
		0
8,120	INTEREST	
		0
8,130	DEPRECI	0
		0
9,510	INTERES	(7,847)
9,520	MISC NO	(2,000)
4,220		0
8,100		459,900
9,702		0
5,230		0
		272,426

Expenses Fixed Assets

0