

		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>0053405</u></p> <p>Facility Name: <u>Walnut Manor</u></p> <p>Address: <u>308 South Second St</u> <u>Walnut</u> <u>61376</u> Number City Zip Code</p> <p>County: <u>Bureau</u></p> <p>Telephone Number: <u>815 379-2131</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>Jan 2015</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><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" style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP & CFO</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()</td> </tr> </table> <p align="center">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) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP & CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<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 _____																												
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP & CFO</u>																												
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()																												

Facility Name & ID Number Walnut Manor

0053405 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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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	9,919	7,412	1,349	18,680	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,919	7,412	1,349	18,680	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.55%

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

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

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

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

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 Jan 2015

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

YES Date Jan 2015 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 1,349

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Walnut Manor

0053405

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				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	172,755	10,829		183,584		183,584	3,308	186,892		1
2	Food Purchase		140,136		140,136		140,136	19	140,155		2
3	Housekeeping	71,521	14,006		85,527		85,527	24	85,551		3
4	Laundry	51,570	9,411		60,981		60,981		60,981		4
5	Heat and Other Utilities			61,503	61,503		61,503	859	62,362		5
6	Maintenance	28,604	49,558	34,666	112,828		112,828	10,117	122,945		6
7	Other (specify):*										7
8	TOTAL General Services	324,450	223,940	96,169	644,559		644,559	14,327	658,886		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	964,416	65,576	7,866	1,037,858		1,037,858	(7,639)	1,030,219		10
10a	Therapy		266,954	311,614	578,568	(271,673)	306,895		306,895		10a
11	Activities	52,672	15,351		68,023		68,023		68,023		11
12	Social Services	17,052		2,430	19,482		19,482		19,482		12
13	CNA Training							589	589		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,034,140	347,881	327,910	1,709,931	(271,673)	1,438,258	(7,050)	1,431,208		16
	C. General Administration										
17	Administrative	82,080			82,080		82,080		82,080		17
18	Directors Fees										18
19	Professional Services			174,735	174,735		174,735	(154,997)	19,738		19
20	Dues, Fees, Subscriptions & Promotions			85,743	85,743	(33,945)	51,798	(33,378)	18,420		20
21	Clerical & General Office Expenses	106,044	21,100	4,912	132,056		132,056	197,930	329,986		21
22	Employee Benefits & Payroll Taxes			356,473	356,473		356,473	29,557	386,030		22
23	Inservice Training & Education			7,983	7,983		7,983	138	8,121		23
24	Travel and Seminar			8,618	8,618		8,618	(3,619)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,989	34,989		34,989	8,561	43,550		26
27	Other (specify):*			19,200	19,200		19,200	(19,200)			27
28	TOTAL General Administration	188,124	21,100	692,653	901,877	(33,945)	867,932	24,992	892,924		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,546,714	592,921	1,116,732	3,256,367	(305,618)	2,950,749	32,269	2,983,018		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 Walnut Manor

#0053405

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							68,772	68,772			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,860	20,860		20,860	47,291	68,151			32
33	Real Estate Taxes							34,356	34,356			33
34	Rent-Facility & Grounds			272,040	272,040		272,040	(268,497)	3,543			34
35	Rent-Equipment & Vehicles			2,392	2,392		2,392	4,938	7,330			35
36	Other (specify):*											36
37	TOTAL Ownership			295,292	295,292		295,292	(113,140)	182,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					271,673	271,673	19,816	291,489			39
40	Barber and Beauty Shops			11,879	11,879		11,879		11,879			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					33,945	33,945		33,945			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			11,879	11,879	305,618	317,497	19,816	337,313			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,546,714	592,921	1,423,903	3,563,538		3,563,538	(61,055)	3,502,483			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 Walnut Manor

0053405

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				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	15			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	(7,743)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,420)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,200)			24
25	Fund Raising, Advertising and Promotional	(37,960)			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)	\$ (74,308)		\$	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)	13,253		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,253		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (61,055)		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

Walnut Manor

ID# 0053405

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line Reference

NON-ALLOWABLE EXPENSES

Amount

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		(9,420)	19	22
23				23
24		(19,200)	27	24
25		(37,960)	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		(66,580)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walnut Manor# 0053405

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	3,308	0	0	0	0	0	0	0	0	3,308	1
2	Food Purchase	0	0	19	0	0	0	0	0	0	0	0	19	2
3	Housekeeping	0	0	24	0	0	0	0	0	0	0	0	24	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	859	0	0	0	0	0	0	0	0	859	5
6	Maintenance	0	0	10,117	0	0	0	0	0	0	0	0	10,117	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	14,327	0	0	0	0	0	0	0	0	14,327	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	(8,029)	390	0	0	0	0	0	0	0	0	(7,639)	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	589	0	0	0	0	0	0	0	0	589	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	(8,029)	979	0	0	0	0	0	0	0	0	(7,050)	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	(9,420)	(157,453)	11,876	0	0	0	0	0	0	0	0	(154,997)	19
20	Fees, Subscriptions & Promotions	(37,960)	0	4,582	0	0	0	0	0	0	0	0	(33,378)	20
21	Clerical & General Office Expenses	0	0	197,930	0	0	0	0	0	0	0	0	197,930	21
22	Employee Benefits & Payroll Taxes	0	0	29,557	0	0	0	0	0	0	0	0	29,557	22
23	Inservice Training & Education	0	(485)	623	0	0	0	0	0	0	0	0	138	23
24	Travel and Seminar	(7,743)	0	4,124	0	0	0	0	0	0	0	0	(3,619)	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	8,561	0	0	0	0	0	0	0	0	8,561	26
27	Other (specify):*	(19,200)	0	0	0	0	0	0	0	0	0	0	(19,200)	27
28	TOTAL General Administration	(74,323)	(157,938)	257,253	0	0	0	0	0	0	0	0	24,992	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,323)	(165,967)	272,559	0	0	0	0	0	0	0	0	32,269	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walnut Manor# 0053405

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	56,614	0	12,158	0	0	0	0	0	0	0	68,772	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	15	47,314	0	(38)	0	0	0	0	0	0	0	47,291	32
33	Real Estate Taxes	0	34,356	0	0	0	0	0	0	0	0	0	34,356	33
34	Rent-Facility & Grounds	0	(272,040)	0	3,543	0	0	0	0	0	0	0	(268,497)	34
35	Rent-Equipment & Vehicles	0	0	0	4,938	0	0	0	0	0	0	0	4,938	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	15	(133,756)	0	20,601	0	0	0	0	0	0	0	(113,140)	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	19,816	0	0	0	0	0	0	0	0	0	19,816	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	19,816	0	0	0	0	0	0	0	0	0	19,816	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(74,308)	(279,907)	272,559	20,601	0	0	0	0	0	0	0	(61,055)	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
Heritage Enterprises, Inc.	100	Attached Following This Page		Heritage Operations Group	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	10 Adjustment for Related Organization	\$	GreenTree Pharmacy	0.00%	\$ (8,029)	\$ (8,029)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(485)	(485)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	19,816	19,816	3
4	V	19 Adjustment for Related Organization	157,453	Heritage Operations Group, LLC	0.00%		(157,453)	4
5	V							5
6	V	34 Adjustment for Related Organization	272,040	Heritage Manor Real Estate, LLC	0.00%		(272,040)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		34,356	34,356	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,001	46,001	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		56,614	56,614	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,313	1,313	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 429,493			\$ 149,586	\$ * (279,907)	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.		\$	\$	3,308 15
16	V	2 Food Purchase						19 16
17	V	3 Housekeeping						24 17
18	V	4 Laundry						0 18
19	V	5 Heat & Other Utilities						859 19
20	V	6 Maintenance						10,117 20
21	V	7 Other						0 21
22	V	9 Medical Director						0 22
23	V	10 Nursing & Medical Records						390 23
24	V	11 Activities						0 24
25	V	12 Social Service						0 25
26	V	13 Nurse Aide Training						589 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						11,876 31
32	V	20 Fees, Subscription, Promotions						4,582 32
33	V	21 Clerical & General Office Expenses						197,930 33
34	V	22 Employee Benefits & Payroll Taxes						29,557 34
35	V	23 Inservice Training & Education						623 35
36	V	24 Travel and Seminar						4,124 36
37	V	25 Other Admin. Staff Transportation						0 37
38	V	26 Insurance-Prop.Liab.Malpract						8,561 38
39	Total		\$			\$	0	\$ * 272,559 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						12,158 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						(38) 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						3,543 20
21	V	35 Rent-Equipment & Vehicles						4,938 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							0 28
29	V							0 29
30	V							0 30
31	V							0 31
32	V							0 32
33	V							0 33
34	V							0 34
35	V							0 35
36	V							0 36
37	V							0 37
38	V							0 38
39	Total		\$			\$	\$	0 * 20,601 39

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

Facility Name & ID Number Walnut Manor # 0053405 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 Walnut Manor

0053405

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	62	\$ 3,308	1
2	2	Food Purchase	Beds	2,835	27	878	0	62	19	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	62	24	3
4	4	Laundry	Beds	2,835	27	0	0	62	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	62	859	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	62	10,117	6
7	7	Other	Beds	2,835	27	0	0	62	0	7
8	9	Medical Director	Beds	2,835	27	0	0	62	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	62	390	9
10	11	Activities	Beds	2,835	27	0	0	62	0	10
11	12	Social Service	Beds	2,835	27	0	0	62	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	62	589	12
13	14	Program Transportation	Beds	2,835	27	0	0	62	0	13
14	15	Other	Beds	2,835	27	0	0	62	0	14
15	17	Administrative	Beds	2,835	27	0	0	62	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	62	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	62	11,876	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	62	4,582	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	62	197,930	19
20	22	Employee Benefits & Payroll Tax	Beds	2,835	27	1,351,528	0	62	29,557	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	62	623	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	62	4,124	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0	62	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0	62	8,561	24
25	TOTALS					\$ 12,462,987	\$ 8,837,683		\$ 272,559	25

Facility Name & ID Number Walnut Manor

0053405

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	\$	\$	62	\$	1
2	30	Depreciation	Beds	2,835	27	555,915	62	12,158	2	
3	31	Amortization of Pre-Op & Org	Beds	2,835	27		62		3	
4	32	Interest	Beds	2,835	27	(1,746)	62	(38)	4	
5	33	Real Estate Taxes	Beds	2,835	27		62		5	
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022	62	3,543	6	
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798	62	4,938	7	
8	36	Other	Beds	2,835	27		62		8	
9	38	Medically Nec Transportation	Beds	2,835	27		62		9	
10	39	Ancillary Service Centers	Beds	2,835	27		62		10	
11	40	Barber and Beauty Shops	Beds	2,835	27		62		11	
12	41	Coffee and Gift Shops	Beds	2,835	27		62		12	
13	42	Other	Beds	2,835	27		62		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	\$	\$	20,601	\$	25

Facility Name & ID Number

Walnut Manor

0053405

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**					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	Morton Community Bank		x	Mortgage			\$	\$			\$ 46,001 1					
2	Morton Community Bank		x	Loan Fee Amortization							1,313 2					
3											3					
4											4					
5											5					
Working Capital																
6	Bank of America		x	Working Capital							20,860 6					
7											7					
8											8					
9	TOTAL Facility Related						\$	\$			\$ 68,174 9					
B. Non-Facility Related*																
10	Interest Income										15 10					
11											11					
12	Allocated Corporate										(38) 12					
13											13					
14	TOTAL Non-Facility Related						\$	\$			\$ (23) 14					
15	TOTALS (line 9+line14)						\$	\$			\$ 68,151 15					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 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.)		\$	34,356		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	34,356		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.		\$	34,356		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	34,286	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: right;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: right;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: right;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: right;">16</td> </tr> </table>		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
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																	
	2011	26,663	9																
	2012	34,518	10																
	2013	33,172	11																
	2014	34,356	12																

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 Walnut Manor COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 15784

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>03-17-100-003</u>	_____	\$ <u>42,686.66</u>	\$ <u>34,150.00</u>
2. <u>03-17-202-001</u>	_____	\$ <u>257.82</u>	\$ <u>206.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>42,944.48</u></u>	\$ <u><u>34,356.00</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? x 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 Walnut Manor

0053405 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,000 (est) 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).

Walnut Apartments - Independent living units located adjacent to SNF facility. Only combined cost is real estate tax expense

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>20,610</u>	1
2					2
3	TOTALS			\$ <u>20,610</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	Adjustments	Accumulated Depreciation
4	62			\$ 469,470	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Improvements		1977	1,605					
10	Improvements		1979	15					
11	Improvements		1978	3,737					
12	Improvements		1980	12,962					
13	Improvements		1981	6,721					
14	Improvements		1982	2,572					
15	Improvements		1983	1,394					
16	Improvements		1984	10,068					
17	Improvements		1985	2,599					
18	Improvements		1988	6,911					
19	Improvements		1991	15,262					
20	Improvements		1992	28,595					
21	Improvements		1993	8,420					
22	Improvements		1994	12,336					
23	Improvements		1995	14,430					
24	Improvements		1996	10,346					
25	Improvements		1999	17,393					
26	Wander Guard System		2000	760					
27	Fire Alarm		2000	675					
28	Main Entrance Alarm		2000	2,422					
29	Drapes		2001	1,126					
30	Fire Doors		2001	2,255					
31									
32									
33	C/O Allocation				12,158		12,158		
34	Book Depreciation				48,838		48,838		
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

Facility Name & ID Number Walnut Manor

0053405

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	
37	Living Room Railing	2001	\$ 444	\$		\$	\$	\$	37
38	Drapes	2001	967						38
39									39
40	Improvements	1973	22,000						40
41	Improvements	1976	1,055						41
42	Improvements	1978	73						42
43	Improvements	1980	48						43
44	Improvements	1982	1,616						44
45	Improvements	1983	1,330						45
46	Improvements	1984	213						46
47	Improvements	1985	11,880						47
48	Improvements	1988	400						48
49	Improvements	1995	8,735						49
50									50
51	Retention Pond	1997	7,565						51
52									52
53	Improvements	1978	53,783						53
54	Improvements	1979	1,207						54
55	Improvements	1982	105						55
56	Improvements	1984	310						56
57	Improvements	1985	1,107						57
58	Improvements	1986	570						58
59	Improvements	1987	1,811						59
60	Improvements	1988	575						60
61	Improvements	1989	3,412						61
62	Improvements	1990	10,184						62
63	Improvements	1991	3,193						63
64	Improvements	1994	11,944						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 776,601	\$ 60,996		\$ 60,996	\$	\$	70

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

Facility Name & ID Number Walnut Manor

0053405

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		\$ 776,601	\$ 60,996		\$ 60,996	\$	\$	1
2									2
3	Cabinets	1998	3,647						3
4	Bathroom Fixtures	1999	18,379						4
5	Doors	1999	4,900						5
6	Furnace	2001	1,527						6
7	Air Conditioner	2001	1,435						7
8									8
9	Smoke Detector	2002	2,754						9
10	Emergency Lights	2002	1,188						10
11	Fire Dampers	2002	6,455						11
12	Insulated Door	2002	635						12
13									13
14	Heating Ducts	2003	6,455						14
15	Shower Stall	2003	1,410						15
16	Rooftop A/C	2003	7,550						16
17									17
18	Door Monitor	2004	3,528						18
19	3 Keyless Door Locks	2004	1,086						19
20									20
21	Boiler	2005	3,725						21
22	Water Heater	2005	4,700						22
23	Door Frames	2005	1,217						23
24	Fire Ext	2005	1,632						24
25	A/C Condenser	2005	1,850						25
26	MedCare Stand	2005	1,217						26
27									27
28	Foundation repair	2006	2,992						28
29	Valve -- Water Heater	2006	587						29
30	Service sink	2006	912						30
31	Building wiring	2006	6,659						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 863,041	\$ 60,996		\$ 60,996	\$	\$	34

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

Facility Name & ID Number Walnut Manor

0053405

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		\$ 863,041	\$ 60,996		\$ 60,996	\$	\$	1
2									2
3	Furnace	2007	2,851						3
4	HVAC Air handler	2007	7,400						4
5	Downflow a/c coil	2007	3,555						5
6	2 Hanging furnaces	2007	7,458						6
7	Window	2007	1,512						7
8									8
9	Compressor	2008	1,338						9
10	Corridor painting	2008	1,700						10
11	Parking Lot Seal	2008	7,850						11
12	A/C condensor	2008	6,886						12
13	Smoke Damper	2008	2,455						13
14	Laundry Room A/C	2008	6,088						14
15									15
16	Corridor Renovation: Paint, lighting, flooring & Décor	2009	48,271						16
17	Therapy Room Renovation: Paint & Décor	2009	4,100						17
18	Wanderguard	2009	3,250						18
19	West Wing Air Handler	2009	6,265						19
20	Patio Renovation: Concrete	2009	4,219						20
21	Garage Siding	2009	3,634						21
22	Roof	2009	21,328						22
23									23
24	Phone system	2010	3,118						24
25	Sidewalk	2010	3,188						25
26	Fence	2010	3,900						26
27	Tile & Plumbing Kitchen	2010	24,051						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,037,458	\$ 60,996		\$ 60,996	\$	\$	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		\$ 1,037,458	\$ 60,996		\$ 60,996	\$	\$	1
2									2
3	Sprinkler System	2011	90,602						3
4	Ceramic Tile	2011	5,868						4
5	Water Heater	2011	7,595						5
6	Fire Alarm	2011	6,875						6
7	A/C for Therapy Room	2011	7,456						7
8	Aquaclean extractor	2011	3,175						8
9	Asphalt Sealer	2011	7,000						9
10									10
11	Water Heater	2012	5,600						11
12	Doors	2012	3,308						12
13	WiFi Equipment/Installation	2012	5,804						13
14	Boiler	2012	9,125						14
15									15
16	HVAC Unit Purchase and Installation	2013	4,241						16
17	Replace and Install 4 Ton A/C Units (2)	2014	6,320						17
18	Replace and Install New Water Heater	2014	7,200						18
19									19
20	Construct new sign depicting new facility name	2015	10,557						20
21	Dining room remodeling - removal of old flooring, asbestos	2015	15,426						21
22	removal, new flooring, painting, new plumbing and new								22
23	light fixtures.								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)		\$ 1,233,610	\$ 60,996		\$ 60,996	\$	\$	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	\$ 440,886	\$ 7,776	\$ 7,776	\$		\$	71
72	Current Year Purchases	43,041						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 483,927	\$ 7,776	\$ 7,776	\$		\$	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		2008 Van	2007	\$ 58,504	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 58,504	\$	\$	\$		\$	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)	\$ 1,796,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,772	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,772	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 Walnut Manor

0053405

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: \$ 2,392 Description: Televisions and office equipment

(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.

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 147,622	\$		\$ 147,622	1
2	Licensed Speech and Language Development Therapist		hrs				8,665			8,665	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				148,340	2,268		150,608	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					264,686		264,686	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						6,987			6,987	13
14	TOTAL			\$			\$ 311,614	\$ 266,954		\$ 578,568	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 Walnut Manor# 0053405Report 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	\$ 4,936	\$	1
2	Cash-Patient Deposits	1,277		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	785,643		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,721		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	574,553		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,383,130	\$	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)	\$ 1,383,130	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 219,139	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	277		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,092		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,762		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>	17,548		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 353,818	\$	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)	\$ 353,818	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,029,312	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,383,130	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 853,045	1
2	Restatements (describe):		2
3	Net Income 10/2014 - 12/2014	61,459	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 914,504	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	114,808	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)	\$ 114,808	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)	\$ 1,029,312	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,172,063	1
2	Discounts and Allowances for all Levels	(996,615)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,175,448	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	973,598	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 973,598	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,065	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	516,029	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	221	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 529,315	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(15)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (15)	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)	\$ 3,678,346	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	644,559	31
32	Health Care	1,709,931	32
33	General Administration	901,877	33
B. Capital Expense			
34	Ownership	295,292	34
C. Ancillary Expense			
35	Special Cost Centers	11,879	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)*	\$ 3,563,538	40
41	Income before Income Taxes (line 30 minus line 40)**	114,808	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 114,808	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 Walnut Manor

0053405

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	1,824	1,920	\$ 69,327	\$ 36.11	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	6,597	6,944	179,340	25.83	3
4	Licensed Practical Nurses	10,636	11,196	258,509	23.09	4
5	CNAs & Orderlies	35,861	37,748	457,240	12.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	4,036	4,248	52,672	12.40	10
11	Social Service Workers	934	983	17,052	17.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,691	16,517	172,755	10.46	15
16	Dishwashers					16
17	Maintenance Workers	1,788	1,882	28,604	15.20	17
18	Housekeepers	6,253	6,582	71,521	10.87	18
19	Laundry	5,240	5,516	51,570	9.35	19
20	Administrator	1,976	2,080	82,080	39.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,556	4,796	106,044	22.11	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)	95,392	100,412	\$ 1,546,714 *	\$ 15.40	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	6,000		36
37	Medical Records Consultant	4,231		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,091		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	2,430		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 15,752		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

Facility Name & ID Number Walnut Manor

0053405

Report Period Beginning: 01/01/15

Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Dennis Grobe	Administrator		\$ 82,080	Workers' Compensation Insurance	\$ 23,364	IDPH License Fee	\$	
				Unemployment Compensation Insurance	4,440	Advertising: Employee Recruitment	6,499	
				FICA Taxes	118,324	Health Care Worker Background Check		
				Employee Health Insurance	188,517	(Indicate # of checks performed)	867	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		PR	12,325	
				Other Benefits	21,828	Dues & Subscriptions	4,972	
				Central Office Allocation	29,557	License & Fees	3,999	
						Central Office Allocation	4,582	
						Less: Public Relations Expense	(12,325)	
						Non-allowable advertising	(2,499)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,080	TOTAL (agree to Schedule V, line 22, col.8)	\$ 386,030	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,420	
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	
								5,640
								13
							Seminar Expense	2,965
								(3,619)
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 4,999
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Operations Group	Mgt		\$ 157,474					
ADP	Payroll tax processing		1,020					
Consova	HR consulting		299					
Sulaski & Webb	Tax		1,900					
Principal Financial Group	Benefits admin		1,635					
McQuellon Group	Real estate tax appeal		2,987					
Legal adj to Zero			9,420					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 174,735					

* 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 Walnut Manor

0053405

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. \$ 33,945
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. \$ 5,675
- (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	4,936				1,009	1,009 PETTY C 4,936
1010	CASH IN BANK					1,100	1,100 ACCTS R 858,138
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. (72,495)
1100	ACCOUNTS RECEIVABLE	785,643				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 16,721
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	16,721				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	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 1,277
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	1,277				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC 574,553
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (219,139)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	574,553				2,100	2,100 ACCRUE (20,534)
2010	ACCOUNTS PAYABLE	-219,139				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-20,534				2,110	2,110 ACCRUE (94,558)
2110	ACCRUED VACATION PAY	-94,558				2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(1,762)	
2125	FICA TAX PAYABLE	-1,762	-1,762	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/F		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE G.		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(17,548)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-17,548		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO	(277)	
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	(914,504)	
2460	INCOME TAXES PAYABLE				net income	(114,808)	
2512	DUE TO RESIDENTS	-277					
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	-914,504					
2970	PROFIT/LOSS FOR PERIOD	-114,808					
3007.1	PATIENT DAYS-PRIVATE	7,412					3,007

3007.2	PATIENT DAYS-IPA	9,919						3,007
3007.3	PATIENT DAYS-MEDICARE	1,349						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-3,151,266	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	-14,321	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	-516,029	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-973,598	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	996,615	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	-13,065		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	-6,476		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	-221		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	99,381	106,044	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	82,080	82,080	17	1	0	0		4,120
4115	VACATION & SICK - G&A	6,663		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	14,872	356,473	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	6,956		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	0		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	21,100	21,100	21	2	0	0		4,275
4260	TELEPHONE	4,912	4,912	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	7,983	7,983	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	5,640	8,618	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	13		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	2,965		24	3	19	-7,743 ***		4,289
4290	HELP WANTED ADVERTISING	6,499	85,743	20	3	0	0 -33,945		4,290
4291	PROMOTIONAL ADVERTISING	23,136		20	3	25	-23,136		4,291
4292	PUBLIC RELATIONS	12,325		20	3	25	-12,325		4,292
4300	LICENSES & FEES	37,944		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	4,972		20	3	17	-2,499		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	17,282	174,735	19	3	22	-9,420		4,350
4355	MEDICAL DIRECTOR	6,000	6,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	4,231		10	3	0	0	4,364
4363	PHARMACIST FEES	3,091		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	2,430	2,430	12	3	0	0	4,383
4370	TV RENTAL	125		35	3	5	0	4,390
4380	INCOME TAXES		19,200	27	3	26	0	4,400
4383	BACKGROUND CHECKS	867		20	3	26	0	4,401
4400	PAYROLL TAXES	114,244		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,520		22	3	0	0	4,420
4410	GROUP INSURANCE	188,517		22	3	0	0	4,430
4420	LIABILITY INSURANCE	34,989	34,989	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	23,364		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	157,453		19	3	34	0 **	4,460
4460	BAD DEBTS	19,200		27	3	24	-19,200	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	2,267	2,392	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	26,307	28,604	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	2,297		6	1	0	0	4,510
5130	ELECTRIC	28,291	61,503	5	3	0	0	4,600
5131	NATURAL GAS	13,000		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	20,212		5	3	0	0	5,130
5134	TRASH COLLECTION	10,810	34,666	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	4,620	49,558	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	44,938		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	23,856		6	3	0	0	5,140
5210	DIETARY WAGES	160,660	172,755	1	1	0	0	5,160
5220	DIETARY SICK & VAC	12,095		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	145,811	140,136	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	1,937	10,829	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	999		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,893		1	2	0	0	5,260
5295	MEAL CREDIT	-5,675		2	2	0	0	5,270
5310	LAUNDRY WAGES	48,293	51,570	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,277		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	6,399	9,411	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	3,012		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	66,756	71,521	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	4,765		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	14,006	14,006	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	0		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		964,416	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	163,459		10	1	0	0	6,020
6030	DON WAGES	69,327		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	15,881		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	237,666		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	20,843		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	428,028		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	29,212		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	41,527	65,576	10	2	0	0	7,281
6295	NURSING SUPPLIES	21,622		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	2,427		10	2	0	0	7,391
6490	NURSING OTHER	544	7,866	10	3	0	0	7,393
7280	DRUG PURCHASES	61,644	266,954	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	203,042		39	2			7,540
7380	LABORATORY SERVICES	6,987	311,614	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	49,659	52,672	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	3,013		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	15,351	15,351	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	148,340		39	3	0	0 ***	7,890
7660	PT SUPPLIES	2,268		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	15,440	17,052	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,612		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	147,622		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	8,665		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	11,486	11,486	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	393	393	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	272,040	272,040	34	3	0	0	

8120	INTEREST EXPENSE	20,860	20,860	32	3	14	15	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	15		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		3,563,553	3,563,538					
			-15					

GRAND TOTALS

-114,808
(NET INCOME) -74,308

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP	7,412	7,412
IPA	9,919	9,919
medicare	1,349	1,349
		18,680

UND

RIA

BT

BT

3,007 PATIENT	9,919
3,007 PATIENT	1,349
	0

3,010 BASIC CI	(3,151,266)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(14,321)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(516,029)
	0

3,110 PHYSICIAN	(973,598)
	0

3,112 PHYSICIAN	0
3,113 PHYSICIAN	0

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

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	970,197
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3,520 RENT INCOME	
3,530 BEAUTY	(13,065)
	0
3,570 VENDING INCOME & EXPENSE	
3,590 EQUIPMI	(6,476)
3,595 RESIDEN	0
3,600 MISC INC	(221)
4,110 G&A WA	99,381
4,111 ADMINIS	82,080
4,115 G&A PTC	6,663
4,120 EMPLOY	14,887
4,130 EMPLOY	6,956
4,135 EMPLOYEE SCHOLARSHIPS-COSTS	
4,250 OFFICE S	9,365
4,255 POSTAGI	2,094
4,260 TELEPHC	4,912
4,275 TRAININ	7,983
	0
4,280 GENERA	5,640
4,281 MEAL EX	13
4,285 EDUCAT	2,444
4,289 MEETINC	521
4,290 HELP WA	6,499
4,291 PROMOT	23,136
4,292 PUBLIC I	12,325
4,300 LICENSE	37,944
4,310 DUES & :	4,972
4,320 CONTRIBUTIONS	
4,350 PROFESS	17,282
4,355 MEDICAL	6,000
	4,231
	3,091

4,364 SOCIAL S	2,430
4,370 TV RENT	125
4,383 BACKGR	867
4,390 OTHER T	0
4,400 PAYROL	114,244
4,401 PAYROL	8,520
4,410 GROUP I	188,517
4,420 LIABILIT	34,989
4,430 WORKM.	22,893
4,435 W/C-FIRST AID CLAIMS	
4,436 DRUG TE	471
4,450 MANAGI	157,453
4,460 BAD DEF	19,200
4,461 BAD DEF	26,418
4,470 LOST ITE	0
4,475 UNIFORM	(15)
4,486 SERVICE	14,523
4,490 MISC EX	563
4,496 MISC. M.	9,641
4,510 REAL ES	0
4,600 LEASED	2,267
5,110 MAINTEN	26,307
5,120 MAINTEN	2,297
5,130 ELECTRI	28,291
5,131 NATURA	13,000
5,133 WATER &	20,212
5,134 TRASH C	10,810
5,140 PROP/PL	4,620
5,160 GENERA	44,938
5,165 MAINTEN	9,333
5,210 DIETARY	160,660
5,220 DIETARY	12,095
5,248 FOOD PU	145,248

5,250 SUPPLIE	1,937
5,260 REPLACI	999
5,270 KITCHEN	7,893
5,295 MEAL IN	(5,675)
5,310 LAUNDR	48,293
5,340 LAUNDR	3,277
5,370 REPLACI	6,399
	0
5,390 SUPPLIE	3,012
5,410 HOUSEK	66,756
5,440 HOUSEK	4,765
5,480 SUPPLIE	14,006
5,490 SUPPLIES-HOUSEKEEPING	
6,020 RN WAG	163,459
6,030 DON WA	69,327
6,035 ADON WAGES	
6,040 RN PTO &	15,881
6,120 LPN WAG	237,666
6,140 LPN PTO	20,843
6,220 AIDES W	428,028
6,240 AIDES PT	29,212
6,245	
	0
	0
	0
6,270 REHAB WAGES	
6,275 REHAB PTO & RESERVE	
6,290 NURSINC	41,527
6,295 NURSINC	21,622
6,390 REPLACI	2,427
6,490 OTHER	544

7,280 DRUG PU	61,644
7,281 DRUG PU	203,042
7,380 LABORA	0
7,390 X-RAY SERVICES EXPENSE	
	6,987
7,510 ACTIVIT	49,659
7,540 ACTIVIT	3,013
7,590 ACTIVIT	15,351
7,620 PHYSICA	148,340
7,660 P.T. SUPE	2,268
7,710 SOCIAL S	15,440
7,720 SOCIAL S	1,612
7,730 SOCIAL S	0
7,740 OCCUPA	147,622
7,770 SPEECH '	8,665
7,820 BEAUTIC	11,486
	393
	0
8,120 INTERES	0
	20,860
8,130 DEPRECI	0
	0
9,510 INTERES	15
9,520 MISC NO	0
4,220	0
8,100	272,040
9,702	0
5,230	0
	<u>(114,808)</u>

Expenses Fixed Assets

