

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0007880

Facility Name: Country Health

Address: 2304 C R 3000 N Gifford 61847
Number City Zip Code

County: Champaign

Telephone Number: 217-568-7362 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1970

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Craig Ater 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 01/01/12 to 12/31/12 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) Craig Ater
(Title) Exec VP & 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 Country Health

0007880 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	89	Skilled (SNF)	89	32,574	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	89	TOTALS	89	32,574	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,082	13,801	4,333	29,216	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,082	13,801	4,333	29,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.69%

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?

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 1970

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 4,333

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL x MODIFIED CASH* CASH*

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

Tax Year: Fiscal Year:

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
	A. General Services	1	2	3	4	5	6	7	8	9	10
1	Dietary	247,666	17,912		265,578		265,578		265,578		1
2	Food Purchase		195,987		195,987		195,987		195,987		2
3	Housekeeping	116,524	24,514		141,038		141,038		141,038		3
4	Laundry	62,587	12,147		74,734		74,734		74,734		4
5	Heat and Other Utilities			178,147	178,147		178,147		178,147		5
6	Maintenance	69,083	65,156	49,023	183,262		183,262		183,262		6
7	Other (specify):*										7
8	TOTAL General Services	495,860	315,716	227,170	1,038,746		1,038,746		1,038,746		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	1,695,822	122,967	6,767	1,825,556		1,825,556		1,825,556		10
10a	Therapy		297,681	644,890	942,571	(370,737)	571,834		571,834		10a
11	Activities	65,553	4,154		69,707		69,707		69,707		11
12	Social Services	31,512		3,175	34,687		34,687		34,687		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,792,887	424,802	668,032	2,885,721	(370,737)	2,514,984		2,514,984		16
	C. General Administration										
17	Administrative	80,282			80,282		80,282		80,282		17
18	Directors Fees										18
19	Professional Services			156,195	156,195		156,195	(7,725)	148,470		19
20	Dues, Fees, Subscriptions & Promotions			114,759	114,759	(48,861)	65,898	(51,712)	14,186		20
21	Clerical & General Office Expenses	188,027	16,078	5,498	209,603		209,603		209,603		21
22	Employee Benefits & Payroll Taxes			530,172	530,172		530,172		530,172		22
23	Inservice Training & Education			2,056	2,056		2,056	(57)	1,999		23
24	Travel and Seminar			5,506	5,506		5,506	(3,507)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			142,528	142,528		142,528		142,528		26
27	Other (specify):*			73	73		73		73		27
28	TOTAL General Administration	268,309	16,078	956,787	1,241,174	(48,861)	1,192,313	(63,001)	1,129,312		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,557,056	756,596	1,851,989	5,165,641	(419,598)	4,746,043	(63,001)	4,683,042		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			307,927	307,927		307,927		307,927			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			272,651	272,651		272,651	(5,718)	266,933			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,311	20,311		20,311		20,311			35
36	Other (specify):*											36
37	TOTAL Ownership			600,889	600,889		600,889	(5,718)	595,171			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					370,737	370,737		370,737			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,861	48,861		48,861			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					419,598	419,598		419,598			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,557,056	756,596	2,452,878	5,766,530		5,766,530	(68,719)	5,697,811			45

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

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	(5,718)			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)	(57)			16
17	Non-Care Related Fees	(993)			17
18	Fines and Penalties				18
19	Entertainment	(3,507)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,725)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(50,719)			25
	Income Taxes and Illinois Personal				
26	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)	\$ (68,719)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (68,719)		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

Country Health

ID#

0007880

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(993)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(7,725)	19	22
23				23
24		0	27	24
25		(50,719)	20	25
26				26
27				27
28				28
29			33	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	(59,437)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(7,725)	0	0	0	0	0	0	0	0	0	0	(7,725)	19
20	Fees, Subscriptions & Promotions	(51,712)	0	0	0	0	0	0	0	0	0	0	(51,712)	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	(57)	0	0	0	0	0	0	0	0	0	0	(57)	23
24	Travel and Seminar	(3,507)	0	0	0	0	0	0	0	0	0	0	(3,507)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(63,001)	0	0	0	0	0	0	0	0	0	0	(63,001)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,001)	0	0	0	0	0	0	0	0	0	0	(63,001)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,718)	0	0	0	0	0	0	0	0	0	0	(5,718)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,718)	0	0	0	0	0	0	0	0	0	0	(5,718)	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)	(68,719)	0	0	0	0	0	0	0	0	0	0	(68,719)	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
none						

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

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

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	attached								\$		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 Country Health # 0007880 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 ☐

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

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	United Community		x	Mortgage			\$	7,500,051			\$	272,651	1
2													2
3	EIEC		x	Mortgage				886,094					3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	8,386,145			\$	272,651	9
	B. Non-Facility Related*												
10	Interest Income											(5,718)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(5,718)	14
15	TOTALS (line 9+line14)						\$	8,386,145			\$	266,933	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 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Country Health

COUNTY
Champaign

FACILITY IDPH LICENSE NUMBER
0007880

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 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102

B. General Construction Type: Exterior brick Frame wood

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 27,031	1
2					2
3	TOTALS			\$ 27,031	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	89				\$ 744,720	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1976 Improvements		1976		10,703					9
10	1977 Improvements		1979		15,361					10
11	1978 Improvements		1977		25,766					11
12	1979 Improvements		1978		6,618					12
13	1980 Improvements		1980		30,846					13
14	1981 Improvements		1981		18,567					14
15	1982 Improvements		1982		4,662					15
16	1983 Improvements		1983		28,833					16
17	1984 Improvements		1984		6,700					17
18	1985 Improvements		1985		33,953					18
19	1986 Improvements		1986		23,775					19
20	1987 Improvements		1987		40,603					20
21	1988 Improvements		1988		163,565					21
22	1989 Improvements		1989		50,581					22
23	1990 Improvements		1990		111,695					23
24	1991 Improvements		1991		36,516					24
25	1992 Improvements		1992		26,816					25
26	1993 Improvements		1993		21,383					26
27	1994 Improvements		1994		12,384					27
28	1995 Improvements		1995		5,450					28
29	NURSE CALL SYSTEM		1996		6,349					29
30	DINNING ROOM EXPANSION		1996		10,109					30
31	Dinning Room Remodel		1997		6,121					31
32										32
33										33
34	C/O Allocation									34
35	Book Depreciation					243,383		243,383		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

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	Dinning Room Remodel	1998	\$ 212,044	\$		\$	\$	\$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,891,513	\$ 243,383		\$ 243,383	\$	\$	70

**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 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		\$ 1,891,513	\$ 243,383		\$ 243,383	\$	\$	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,017,721	\$ 243,383		\$ 243,383	\$	\$	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 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		\$ 2,017,721	\$ 243,383		\$ 243,383	\$	\$	1
2									2
3	Resident Room Remodel-- Flooring, paint	2005	696						3
4	Door Alarm	2005	9,840						4
5	Board Room Remodel -- Paint	2005	741						5
6	Activity Room Remodel -- Paint, Flooring	2005	5,359						6
7	Employee Breakroom Remodel -- Paint	2005	1,182						7
8	Chiller	2005	46,799						8
9	Lobby Remodel -- Paint, Flooring	2005	23,981						9
10	Water valves	2005	24,320						10
11	Roof	2005	6,056						11
12	Nurse Call Station	2005	640						12
13	A/C Units	2005	5,127						13
14	Exterior Rehab	2005	1,172						14
15	Parking Lot Resurface	2005	1,449						15
16	CCTV Monitor and Camera	2005	2,407						16
17	Safety Control --Boiler	2005	1,180						17
18	Landscaping	2005	683						18
19	Dining Room Painting	2005	2,375						19
20	Flooring	2005	1,419						20
21									21
22	Dining Room Painting	2006	4,228						22
23	Landscaping	2006	1,411						23
24	Sewage Grinder	2006	18,519						24
25	Sidewalk	2006	1,997						25
26	Fire Door	2006	1,401						26
27	Resident Room Remodel-- Flooring, paint	2006	6,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,187,553	\$ 243,383		\$ 243,383	\$	\$	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 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		\$ 2,187,553	\$ 243,383		\$ 243,383	\$	\$	1
2									2
3	1/2 hp Auto Door Opener	2007	750						3
4	Water Heater	2007	6517						4
5	Roof Repair	2007	851						5
6	Water Main	2007	1462						6
7	Fire System	2007	1662						7
8	Boiler	2007	1044						8
9	Breakers	2007	1393						9
10	Water Softener	2007	1382						10
11									11
12	HVAC Units	2008	3627						12
13	Mixing Valve	2008	8834						13
14	Circulator Pump	2008	2869						14
15									15
16	Water Heater	2009	2860						16
17	Fire Door	2009	4245						17
18									18
19	Water Main	2011	5000						19
20									20
21	Landscapping	2012	18565						21
22	Drywall - Paint & touch-up	2012	3716						22
23	HVAC Compressors	2012	7,500						23
24	Renovation - Contracted Total	2012	6,858,714						24
25	Renovation - Capitalized Interest	2012	673,048						25
26	Renovation - Additional Third Party Costs	2012							26
27	Asbestos	2012	444,405						27
28	Professional Fees	2012	776,516						28
29	Technology	2012	258,985						29
30	Other - Flooring, Drywall Window Treatments	2012	56,856						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,328,354	\$ 243,383		\$ 243,383	\$	\$	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	\$986,802	\$64,544	\$64,544	\$		\$	71
72	Current Year Purchases	337,880						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,324,682	\$64,544	\$64,544	\$		\$	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		\$39,380	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$39,380	\$	\$	\$		\$	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)	\$12,719,447	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$307,927	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$307,927	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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: \$ 20,311
- 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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

	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	\$		\$ 255,947	\$		\$ 255,947	1
2	Licensed Speech and Language Development Therapist		hrs			34,036			34,036	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			281,552	299		281,851	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				297,382		297,382	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					73,355			73,355	13
14	TOTAL			\$		\$ 644,890	\$ 297,681		\$ 942,571	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.

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	\$ 1,198,959	\$	1
2	Cash-Patient Deposits	11,179		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,032,243		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,373		6
7	Other Prepaid Expenses	12,001		7
8	Accounts Receivable (owners or related parties)	1,111		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,311,866	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	680,148		13
14	Buildings, at Historical Cost	11,251,815		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,352,004		16
17	Accumulated Depreciation (book methods)	(2,958,893)		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)	\$ 10,325,074	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,636,940	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 250,420	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,179		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	205,684		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,771		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>Assessment Tax</u>	119,877		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 588,931	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,386,145		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)	\$ 8,386,145	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,975,076	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,661,864	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,636,940	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,349,305	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,349,305	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	312,559	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)	\$ 312,559	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)	\$ 3,661,864	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		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 5,718,087	1	
2Discounts and Allowances for all Levels	(2,468,294)	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,249,793	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy	2,233,722	6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,233,722	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs	541,948	17	
18Sale of Supplies to Non-Patients		18	
19Laboratory		19	
20Radiology and X-Ray		20	
21Other Medical Services	8,108	21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 550,056	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	5,718	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,718	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28	39,800	28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 39,800	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,079,089	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	1,038,746	31	
32Health Care	2,885,721	32	
33General Administration	1,241,174	33	
B. Capital Expense			
34Ownership	600,889	34	
C. Ancillary Expense			
35Special Cost Centers		35	
36Provider Participation Fee		36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,766,530	40	
41Income before Income Taxes (line 30 minus line 40)**	312,559	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 312,559	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$	44	
45Private Pay - Net Inpatient Revenue		45	
46Medicare - Net Inpatient Revenue		46	
47Other-(specify)		47	
48Other-(specify)		48	
49TOTAL 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.

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	1,921	2,080	\$ 58,375	\$ 28.06	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	14,851	15,027	417,771	27.80	3
4	Licensed Practical Nurses	19,792	19,923	472,224	23.70	4
5	CNAs & Orderlies	53,664	54,314	696,366	12.82	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,255	3,270	51,086	15.62	8
9	Activity Director					9
10	Activity Assistants	5,588	5,717	65,553	11.47	10
11	Social Service Workers	1,938	1,963	31,512	16.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,900	22,318	247,666	11.10	15
16	Dishwashers					16
17	Maintenance Workers	4,980	5,020	69,083	13.76	17
18	Housekeepers	11,739	11,809	116,524	9.87	18
19	Laundry	5,875	6,029	62,587	10.38	19
20	Administrator	1,950	2,080	80,282	38.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,008	9,036	188,027	20.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,461	158,586	\$ 2,557,056 *	\$ 16.12	34

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		13,200		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,340		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		3,175		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,715		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Chris Kasper			\$ 80,282	Workers' Compensation Insurance		\$ 45,549	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance		12,812	Advertising: Employee Recruitment	3,063	
				FICA Taxes		195,615	Health Care Worker Background Check		
				Employee Health Insurance		258,711	(Indicate # of checks performed _____)	2,568	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		0		19,162	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		17,485	Dues & Subscriptions	8,647	
(List each licensed administrator separately.)				Central Office Allocation			License & Fees	901	
							Central Office Allocation		
							Less: Public Relations Expense	(19,162)	
							Non-allowable advertising	(993)	
							Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 530,172	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,186	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
				Description	Line #	Amount	Description	Amount	
						\$	Out-of-State Travel	\$	
							In-State Travel		
								4,253	
								43	
							Seminar Expense	1,210	
								(3,507)	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)							(agree to Sch. V, line 24, col. 8)		
(Attach a copy of any management service agreement)							TOTAL		
C. Professional Services									
Vendor/Payee	Type		Amount						
Heritage Operations Group			\$ 136,210						
Sulaski & Webb	audit		7,700						
Principal	401K		1,600						
EIEC	LOC Fee		2,960						
Legal adj to Zero			7,725						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL					
(If total legal fees exceed \$5,000, attach copy of invoices.)									

*** 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	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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. Illinois Health Care Association

(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? _____
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. \$ 48,861
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? yes 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. \$ 4,236

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ 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. \$ _____

(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 out of Schedule V? yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
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	1,198,959				1,009		1,009	PETTY C 1,198,959
1010	CASH IN BANK					1,100		1,100	ACCTS R 1,032,243
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	1,032,243				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 56,373
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	56,373				1,310		1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY
1300	FOOD INVENTORY					1,409		1,409	LAND 680,148
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU 1,352,004
1409	LAND	680,148				1,460			(978,145)
1450	FURNITURE & EQUIPMENT	1,352,004				1,475		1,475	CODE AI #####
1460	ACCUM DEPR-FURN & EQU	-978,145				1,490		1,490	ACCUM I (1,980,748)
1475	BUILDING & IMPROVEMEN	11,251,815				1,530		1,530	RESIDEN 11,179
1490	ACCUM DEPR-BUILDING	-1,980,748				1,550		1,550	LOAN FE 12,001
1530	RESIDENT FUNDS	11,179				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	12,001				1,850		1,850	INTERCC 1,111
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN (250,420)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	1,111				2,100		2,100	ACCRUE (73,578)
2010	ACCOUNTS PAYABLE	-250,420				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-73,578				2,110		2,110	ACCRUE (132,106)
2110	ACCRUED VACATION PAY	-132,106				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(1,771)	
2125	FICA TAX PAYABLE	-1,771	-1,771	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 RE		
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 - CAFETI		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(119,877)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-119,877		2,400	2,400 CURRENT PORTION OF LT DI		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(11,179)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(8,386,145)	
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 DI		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	(3,349,305)	
2460	INCOME TAXES PAYABLE				net income	(312,559)	
2512	DUE TO RESIDENTS	-11,179					
2600	MORTGAGE PAYABLE	-8,386,145					
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>	
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-3,349,305					
2970	PROFIT/LOSS FOR PERIOD	-312,559					
3007.1	PATIENT DAYS-PRIVATE	13,801					3,007

3007.2	PATIENT DAYS-IPA	11,082						3,007
3007.3	PATIENT DAYS-MEDICARE	4,333						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 &	-5,684,076	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	-26,617	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	-541,948	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,233,722	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	2,468,294	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	0		6	0	6	0	3,530
3530	13 BEAUTY SHOP	0		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-7,394		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-8,108		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	176,107	188,027	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	80,282	80,282	17	1	0	0	4,120
4115	VACATION & SICK - G&A	11,920		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	17,485	530,172	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	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	16,078	16,078	21	2	0	0	4,275
4260	TELEPHONE	5,498	5,498	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	2,056	2,056	23	3	16	-57 **	4,280
4280	GENERAL TRAVEL	4,253	5,506	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	43		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	1,210		24	3	19	-3,507 ***	4,289
4290	HELP WANTED ADVERTISING	3,063	114,759	20	3	0	0 -48,861	4,290
4291	PROMOTIONAL ADVERTISING	31,557		20	3	25	-31,557	4,291
4292	PUBLIC RELATIONS	19,162		20	3	25	-19,162	4,292
4300	LICENSES & FEES	49,762		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	8,647		20	3	17	-993	4,310
4320	CONTRIBUTIONS	20		27	3	20	0	4,320
4350	PROFESSIONAL FEES	19,995	156,195	19	3	22	-7,725	4,350
4355	MEDICAL DIRECTOR	13,200	13,200	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 CONSULT	0		10	3	0	0	4,364
4363	PHARMACIST FEES	5,340		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,175	3,175	12	3	0	0	4,383
4370	TV RENTAL	8,014		35	3	5	0	4,390
4380	INCOME TAXES		73	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,568		20	3	26	0	4,401
4400	PAYROLL TAXES	200,094		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,333		22	3	0	0	4,420
4410	GROUP INSURANCE	258,711		22	3	0	0	4,430
4420	LIABILITY INSURANCE	142,528	142,528	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	45,549		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	136,200		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	53		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	12,297	20,311	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	67,892	69,083	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	1,191		6	1	0	0	4,510
5130	ELECTRIC	150,836	178,147	5	3	0	0	4,600
5131	NATURAL GAS	12,433		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	14,878		5	3	0	0	5,130
5134	TRASH COLLECTION	11,755	49,023	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	6,762	65,156	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	58,394		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	37,268		6	3	0	0	5,140
5210	DIETARY WAGES	238,912	247,666	1	1	0	0	5,160
5220	DIETARY SICK & VAC	8,754		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	200,223	195,987	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,981	17,912	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	5,664		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,267		1	2	0	0	5,260
5295	MEAL CREDIT	-4,236		2	2	0	0	5,270
5310	LAUNDRY WAGES	60,127	62,587	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,460		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	8,302	12,147	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	3,845		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	111,504	116,524	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	5,020		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	10,329	24,514	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	14,185		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,695,822	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	403,714		10	1	0	0	6,020
6030	DON WAGES	58,375		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	14,057		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	454,786		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	17,438		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	667,812		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	28,554		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	47,187		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,899		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	110,948	122,967	10	2	0	0	7,281
6295	NURSING SUPPLIES	94		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	11,925		10	2	0	0	7,391
6490	NURSING OTHER	1,427	6,767	10	3	0	0	7,393
7280	DRUG PURCHASES	297,295	297,681	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	87		39	2			7,540
7380	LABORATORY SERVICES	73,355	644,890	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	62,749	65,553	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	2,804		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	4,154	4,154	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	281,552		39	3	0	0 ***	7,890
7660	PT SUPPLIES	299		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	29,917	31,512	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,595		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	255,947		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	34,036		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	271,014	272,651	32	3	14	-5,718	
8130	DEPRECIATION	307,927	307,927	30	3	9	0	
8150	LOAN FEE AMORTIZATION	1,637		32	3	0	0	60,773
9510	INTEREST INCOME	-5,718		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	-39,800		0	0	0	0	
		5,721,012	5,766,530					
			45,518					

GRAND TOTALS

-312,559

-68,719

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	13,801	13,801
IPA	11,082	11,082
medicare	4,333	4,333
		29,216

IPA BEDHOLDS

0

PP BEDHOLDS

0

PP CONVERS

0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 13,801

3,007 PATIENT	11,082
3,007 PATIENT	4,333
	0

3,010 BASIC CI	(5,684,076)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(26,617)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(541,948)
	0

3,110 PHYSICAL	(2,233,722)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

3,140 LABORATORY INCOME	
	0

3,152 ST/OT TR	0
3,153 ST/OT TR	0

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	2,405,896
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3,520 RENT INC	0
3,530 BEAUTY	0
	0
3,570 VENDING	0
3,590 EQUIPM	(7,394)
3,595 RESIDEN	(8,108)
3,600 MISC INC	0
4,110 G&A WA	176,107
4,111 ADMINIS	80,282
4,115 G&A PTC	11,920
4,120 EMPLOY	16,566
	0
4,130 EMPLOY	0
4,135 EMPLOY	0
4,250 OFFICE S	5,746
4,255 POSTAGI	1,966
4,260 TELEPHC	5,498
4,275 TRAININ	2,056
	0
4,280 GENERA	4,253
4,281 MEAL EX	43
4,285 EDUCAT	1,210
4,289 MEETING	0
4,290 HELP WA	3,063
4,291 PROMOT	31,557
4,292 PUBLIC I	19,162
4,300 LICENSE	49,762
4,310 DUES & F	8,647
4,320 CONTRIE	20
4,350 PROFESS	19,995
4,355 MEDICAL	13,200
	0
	5,340

4,364 SOCIAL S	3,175
4,370 TV RENT	8,014
4,383 BACKGR	2,568
4,390 OTHER T	0
4,400 PAYROL	200,094
4,401 PAYROL	8,333
4,410 GROUP I	258,711
4,420 LIABILIT	142,528
4,430 WORKM	42,341
4,435 W/C-FIRS	329
4,436 DRUG TE	2,879
4,450 MANAGI	136,200
4,460 BAD DEF	0
4,461 BAD DEF	62,398
4,470 LOST ITE	53
4,475 UNIFORM	919
4,486 SERVICE	17,445
4,490 MISC EX	321
4,496 MISC. M.	8,366
4,510 REAL ES	0
4,600 LEASED	12,297
5,110 MAINTEN	67,892
5,120 MAINTEN	1,191
5,130 ELECTRI	150,836
5,131 NATURA	12,433
5,133 WATER &	14,878
5,134 TRASH C	11,755
5,140 PROP/PL	6,762
5,160 GENERA	58,394
5,165 MAINTEN	19,823
5,210 DIETARY	238,912
5,220 DIETARY	8,754
5,248 FOOD PU	199,902

5,250 SUPPLIES	2,981
5,260 REPLACEMENTS	5,664
5,270 KITCHEN	9,267
5,295 MEAL IN	(4,236)
5,310 LAUNDRY	60,127
5,340 LAUNDRY	2,460
5,370 REPLACEMENTS	8,302
	6
5,390 SUPPLIES	3,839
5,410 HOUSEKEEPING	111,504
5,440 HOUSEKEEPING	5,020
5,480 SUPPLIES	10,329
5,490 SUPPLIES	14,185
6,020 RN WAGES	403,714
6,030 DONOR WAGES	58,375
6,035 ADONOR WAGES	0
6,040 RN PTO & OVERTIME	14,057
6,120 LPN WAGES	454,786
6,140 LPN PTO	17,438
6,220 AIDES WAGES	667,812
6,240 AIDES PTO	28,554
	0
	0
	0
6,270 REHAB V	47,187
6,275 REHAB P	3,899
6,290 NURSING	110,948
6,295 NURSING	94
6,390 REPLACEMENTS	11,925
6,490 OTHER	1,427

7,280 DRUG PU	297,295
7,281 DRUG PU	87
7,380 LABORA	12,764
7,390 X-RAY S	13,172
	47,419
7,510 ACTIVIT	62,749
7,540 ACTIVIT	2,804
7,590 ACTIVIT	4,154
7,620 PHYSICA	281,552
7,660 P.T. SUP	299
7,710 SOCIAL S	29,917
7,720 SOCIAL S	1,595
7,730 SOCIAL S	0
7,740 OCCUPA	255,947
	0
7,770 SPEECH '	34,036
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	271,014
	0
8,130 DEPRECI	307,927
	1,637
9,510 INTERES	(5,718)
9,520 MISC NO	(39,800)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(312,559)</u>

Expenses Fixed Assets

