

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 48918

Facility Name: Barton W Stone - Jacksonville, LLC.

Address: 873 Grove Street Jacksonville
Number City Zip Code

County: Morgan

Telephone Number: (217)479-3400 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

x

 PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

x

 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 01/01/11 to 12/31/11
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)
(Type or Print Name) Craig Ater
(Title) Exec VP & CFO

Paid
Preparer

(Signed)
(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 Barton W Stone - Jacksonville, LLC.

48918 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	<u>185</u>	Skilled (SNF)	<u>185</u>	<u>67,525</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>24</u>	Sheltered Care (SC)	<u>24</u>	<u>8,760</u>	5
6		ICF/DD 16 or Less			6
7	<u>209</u>	TOTALS	<u>209</u>	<u>76,285</u>	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	<u>28,128</u>	<u>25,256</u>	<u>6,759</u>	<u>60,143</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>1,095</u>	<u>3,819</u>		<u>4,914</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,223</u>	<u>29,075</u>	<u>6,759</u>	<u>65,057</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.28%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

none

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date July 2007 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 6,759

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.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	517,340	23,463		540,803		540,803	11,726	552,529			1
2	Food Purchase		465,225		465,225		465,225	40	465,265			2
3	Housekeeping	260,920	41,009		301,929		301,929	16	301,945			3
4	Laundry	127,971	25,720		153,691		153,691	12	153,703			4
5	Heat and Other Utilities			286,231	286,231		286,231	4,131	290,362			5
6	Maintenance	134,561	158,955	93,031	386,547		386,547	30,395	416,942			6
7	Other (specify):*											7
8	TOTAL General Services	1,040,792	714,372	379,262	2,134,426		2,134,426	46,320	2,180,746			8
	B. Health Care and Programs											
9	Medical Director			8,500	8,500		8,500	169	8,669			9
10	Nursing and Medical Records	3,706,239	232,493	17,622	3,956,354		3,956,354		3,956,354			10
10a	Therapy		726,825	951,248	1,678,073	(781,238)	896,835	343,953	1,240,788			10a
11	Activities	140,099	5,479		145,578		145,578		145,578			11
12	Social Services	76,493	(1,400)	5,090	80,183		80,183		80,183			12
13	CNA Training	13,456	174		13,630		13,630	1,682	15,312			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,936,287	963,571	982,460	5,882,318	(781,238)	5,101,080	345,804	5,446,884			16
	C. General Administration											
17	Administrative	98,548			98,548		98,548	178,435	276,983			17
18	Directors Fees											18
19	Professional Services			511,343	511,343		511,343	(490,014)	21,329			19
20	Dues, Fees, Subscriptions & Promotions			146,379	146,379	(101,288)	45,091	(910)	44,181			20
21	Clerical & General Office Expenses	345,811	36,394	24,603	406,808		406,808	393,698	800,506			21
22	Employee Benefits & Payroll Taxes			1,154,030	1,154,030		1,154,030	82,781	1,236,811			22
23	Inservice Training & Education			374	374		374	1,029	1,403			23
24	Travel and Seminar			4,447	4,447		4,447	(2,448)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,470	100,470		100,470	24,259	124,729			26
27	Other (specify):*			19,667	19,667		19,667	(18,360)	1,307			27
28	TOTAL General Administration	444,359	36,394	1,961,313	2,442,066	(101,288)	2,340,778	168,470	2,509,248			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,421,438	1,714,337	3,323,035	10,458,810	(882,526)	9,576,284	560,594	10,136,878			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 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							376,404	376,404			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,033	18,033		18,033	158,691	176,724			32
33	Real Estate Taxes							88,475	88,475			33
34	Rent-Facility & Grounds			1,038,060	1,038,060		1,038,060	(1,036,067)	1,993			34
35	Rent-Equipment & Vehicles			11,115	11,115		11,115	1,946	13,061			35
36	Other (specify):*											36
37	TOTAL Ownership			1,067,208	1,067,208		1,067,208	(410,551)	656,657			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					781,238	781,238		781,238			39
40	Barber and Beauty Shops		1,054	38,288	39,342		39,342		39,342			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					101,288	101,288		101,288			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,054	38,288	39,342	882,526	921,868		921,868			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,421,438	1,715,391	4,428,531	11,565,360		11,565,360	150,043	11,715,403			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(8,253)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(1,623)	20		17
18	Fines and Penalties				18
19	Entertainment	(22,281)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,285)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,360)	27		24
25	Fund Raising, Advertising and Promotional	(10,846)	20		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)	\$ (73,648)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	223,691		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 223,691		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 150,043		37

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

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

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

ID#48918

Report Period Beginning:01/01/11

Ending:12/31/11

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		(1,623)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(12,285)	19	22
23				23
24		(18,360)	27	24
25		(10,846)	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	(43,114)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Barton W Stone - Jacksonville, LLC. # 48918 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	11,726	0	0	0	0	0	0	0	0	11,726	1
2	Food Purchase	0	0	40	0	0	0	0	0	0	0	0	40	2
3	Housekeeping	0	0	16	0	0	0	0	0	0	0	0	16	3
4	Laundry	0	0	12	0	0	0	0	0	0	0	0	12	4
5	Heat and Other Utilities	0	0	4,131	0	0	0	0	0	0	0	0	4,131	5
6	Maintenance	0	0	30,395	0	0	0	0	0	0	0	0	30,395	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	46,320	0	0	0	0	0	0	0	0	46,320	8
	B. Health Care and Programs													
9	Medical Director	0	0	169	0	0	0	0	0	0	0	0	169	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	343,953	0	0	0	0	0	0	0	0	0	343,953	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	1,682	0	0	0	0	0	0	0	0	1,682	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	343,953	1,851	0	0	0	0	0	0	0	0	345,804	16
	C. General Administration													
17	Administrative	0	0	178,435	0	0	0	0	0	0	0	0	178,435	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,285)	(499,058)	21,329	0	0	0	0	0	0	0	0	(490,014)	19
20	Fees, Subscriptions & Promotions	(12,469)	0	11,559	0	0	0	0	0	0	0	0	(910)	20
21	Clerical & General Office Expenses	0	0	393,698	0	0	0	0	0	0	0	0	393,698	21
22	Employee Benefits & Payroll Taxes	0	0	82,781	0	0	0	0	0	0	0	0	82,781	22
23	Inservice Training & Education	0	0	1,029	0	0	0	0	0	0	0	0	1,029	23
24	Travel and Seminar	(22,281)	0	19,833	0	0	0	0	0	0	0	0	(2,448)	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	24,259	0	0	0	0	0	0	0	0	24,259	26
27	Other (specify):*	(18,360)	0	0	0	0	0	0	0	0	0	0	(18,360)	27
28	TOTAL General Administration	(65,395)	(499,058)	732,923	0	0	0	0	0	0	0	0	168,470	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,395)	(155,105)	781,094	0	0	0	0	0	0	0	0	560,594	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Barton W Stone - Jacksonville, LLC. # 48918 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	351,778	0	24,626	0	0	0	0	0	0	0	376,404	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,253)	165,682	0	1,262	0	0	0	0	0	0	0	158,691	32
33	Real Estate Taxes	0	88,475	0	0	0	0	0	0	0	0	0	88,475	33
34	Rent-Facility & Grounds	0	(1,038,060)	0	1,993	0	0	0	0	0	0	0	(1,036,067)	34
35	Rent-Equipment & Vehicles	0	0	0	1,946	0	0	0	0	0	0	0	1,946	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,253)	(432,125)	0	29,827	0	0	0	0	0	0	0	(410,551)	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)	(73,648)	(587,230)	781,094	29,827	0	0	0	0	0	0	0	150,043	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	See Page 25				

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	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	343,953	343,953	2
3	V								3
4	V	19	Adjustment for Related Organization	499,058	Heritage Operations Group, LLC	0.00%		(499,058)	4
5	V								5
6	V	34	Adjustment for Related Organization	1,038,060	Heritage Manor Real Estate, LLC	0.00%		(1,038,060)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		88,475	88,475	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		161,705	161,705	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		351,778	351,778	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		3,977	3,977	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,537,118			\$ 949,888	\$ * (587,230)	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.		\$	11,726	15
16	V	2	Food Purchase					40	16
17	V	3	Housekeeping					16	17
18	V	4	Laundry					12	18
19	V	5	Heat & Other Utilities					4,131	19
20	V	6	Maintenance					30,395	20
21	V	7	Other					0	21
22	V	9	Medical Director					169	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,682	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					178,435	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					21,329	31
32	V	20	Fees, Subscription, Promotions					11,559	32
33	V	21	Clerical & General Office Expenses					393,698	33
34	V	22	Employee Benefits & Payroll Taxes					82,781	34
35	V	23	Inservice Training & Education					1,029	35
36	V	24	Travel and Seminar					19,833	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					24,259	38
39	Total			\$			\$	0	\$ * 781,094 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					24,626	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					1,262	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					1,993	20
21	V	35	Rent-Equipment & Vehicles					1,946	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	0	\$ * 29,827 39

* 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	Heritage Enterprises Inc.	Member		100.00					\$ 0		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 Barton W Stone - Jacksonville, LLC. # 48918 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	2,735	26	\$ 153,442	\$ 153,115	209	\$ 11,726	1
2	2	Food Purchase	Beds	2,735	26	520	0	209	40	2
3	3	Housekeeping	Beds	2,735	26	215	0	209	16	3
4	4	Laundry	Beds	2,735	26	151	0	209	12	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	209	4,131	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	209	30,395	6
7	7	Other	Beds	2,735	26	0	0	209	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	209	169	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	209	0	9
10	11	Activities	Beds	2,735	26	0	0	209	0	10
11	12	Social Service	Beds	2,735	26	0	0	209	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	209	1,682	12
13	14	Program Transportation	Beds	2,735	26	0	0	209	0	13
14	15	Other	Beds	2,735	26	0	0	209	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	209	178,435	15
16	18	Directors Fees	Beds	2,735	26	0	0	209	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	209	21,329	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	209	11,559	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	5,151,979	4,517,846	209	393,698	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,083,278	0	209	82,781	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	209	1,029	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	209	19,833	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	209	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	209	24,259	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 781,094	25

Facility Name & ID Number Barton W Stone - Jacksonville, LLC. # 48918 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	2,735	26	\$		209	\$	1
2	30	Depreciation	Beds	2,735	26	322,258		209	24,626	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			209		3
4	32	Interest	Beds	2,735	26	16,517		209	1,262	4
5	33	Real Estate Taxes	Beds	2,735	26			209		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		209	1,993	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		209	1,946	7
8	36	Other	Beds	2,735	26			209		8
9	38	Medically Nec Transportation	Beds	2,735	26			209		9
10	39	Ancillary Service Centers	Beds	2,735	26			209		10
11	40	Barber and Beauty Shops	Beds	2,735	26			209		11
12	41	Coffee and Gift Shops	Beds	2,735	26			209		12
13	42	Other	Beds	2,735	26			209		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					\$ 390,316	\$		\$ 29,827	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	Bank of America		xx	Mortgage			\$	3,196,846	03/2016	variable	\$ 161,705
2	Bank of America		xx	Loan Fees							3,977
3											
4											
5											
	Working Capital										
6	Bank of America		xx	Accounts Receivable							18,033
7											
8											
9	TOTAL Facility Related						\$	3,196,846			\$ 183,715
	B. Non-Facility Related*										
10	Interest Income										(8,253)
11	Allocated Corporate										1,262
12											
13											
14	TOTAL Non-Facility Related						\$				\$ (6,991)
15	TOTALS (line 9+line14)						\$	3,196,846			\$ 176,724

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.)

HFS 3745 (N-4-99)

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 2010 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.)			\$	88,475	2
3. Under or (over) accrual (line 2 minus line 1).			\$	88,475	3
4. Real Estate Tax accrual used for 2011 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.			\$	88,475	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	86,524	8	
		2007	82,361	9	
		2008	79,630	10	
		2009	84,129	11	
		2010	88,475	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Barton W Stone - Jacksonville, LLC. COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 48918

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 2010 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 2010.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>0920308003</u>	<u>nursing home</u>	\$ <u>116,415.00</u>	\$ <u>88,475.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>116,415.00</u></u>	\$ <u><u>88,475.00</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? 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies 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				\$ 100,000	1
2					2
3	TOTALS			\$ 100,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209				\$ 3,295,725	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Facility Sign			2005	1,050						9
10	Dietary cabinets			2005	5,864						10
11	Ansul system			2005	1,600						11
12	Heat detectors			2005	1,777						12
13	Door system			2005	17,554						13
14	A/C units			2005	10,456						14
15	Thurnbury door			2005	1,593						15
16	Computer wiring			2005	1,280						16
17	A/C compressor			2005	2,849						17
18	Shelter care remodel-- paint, flooring, wallpaper			2006	225,040						18
19	landscapping			2006	2,262						19
20	Boiler			2006	2,580						20
21	Heat/cool units			2006	9,517						21
22	Fire alarm			2006	2,097						22
23	Roof			2006	145,352						23
24	Door system			2006	414						24
25	Mixing Valve			2006	5,060						25
26	Hutton Hall remodel (Shelter Care) -- Window treatments, painting			2006	31,147						26
27	sump pump			2006	2,001						27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation							24,626	24,626		33
34	Book Depreciation					180,600		180,600			34
35											35
36											36

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

See Page 12A, Line 70 for total

****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	
37	Backflow preventer	2007	\$ 3,501	\$		\$	\$	\$	37
38	Shower/faucet	2007	875						38
39	Air Handler	2007	5,215						39
40	HVAC	2007	20,152						40
41	Tree removal	2007	9,491						41
42	Valance	2007	581						42
43	Younkin corridor remodel -- paint	2007	16,420						43
44	Trane compressor	2007	2,841						44
45	Elevator	2007							45
46	Parking lot	2007							46
47	Door alarm	2007							47
48	fire dampers	2007							48
49	concrete pad	2007							49
50	Sprinkler system	2007							50
51									51
52	Nurse Call System	2008	206,839						52
53	Mechanical systems	2008	12,996						53
54	Condensing Unit	2008	17,965						54
55	Laundry plumbing	2008	12,671						55
56	Heat / Cool units	2008	24,201						56
57	Fire Panel	2008	7,378						57
58	Water Heater	2008	5,272						58
59	Kitchen Air Handler	2008	26,187						59
60	Condensing Unit	2008	4,069						60
61	Wireless Phone system	2008	44,744						61
62	Cables-nurse call	2008	22,788						62
63	Resident Phones	2008	10,081						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,219,485	\$ 180,600		\$ 205,226	\$ 24,626	\$	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		\$ 4,219,485	\$ 180,600		\$ 205,226	\$ 24,626	\$	1
2	Compressor	2009	2,516						2
3	Condensing Unit	2009	16,946						3
4	Boiler Replacement	2009	10,434						4
5	Roof	2009	8,393						5
6	HVAC units	2009	5,735						6
7	Firewall	2009	6,951						7
8	HVAC units	2009	5,106						8
9	Laundry plumbing	2009	7,351						9
10	Sewer ejector	2009	5,189						10
11	Dinning room paint, flooring & labor	2009	55,148						11
12	Cabling	2009	10,874						12
13	Laundry plumbing	2009	7,015						13
14									14
15	Roof Repair	2010	10,654						15
16	heat/cool units	2010	11,449						16
17	Driveway sealant	2010	3,800						17
18	Wanderguard	2010	3,099						18
19	Furnace	2010	4,095						19
20	Carpet	2010	3,523						20
21	Dinning room paint, flooring & labor	2010	53,752						21
22	Boiler Replacement	2010	25,619						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,477,134	\$ 180,600		\$ 205,226	\$ 24,626	\$	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		\$ 4,477,134	\$ 180,600		\$ 205,226	\$ 24,626	\$	1
2									2
3	Islandaire system	2011	8,122						3
4	PTAC units	2011	21,011						4
5	44 windows	2011	73,900						5
6	roof	2011	8,393						6
7	boiler	2011	19,466						7
8	sign	2011	12,169						8
9	Technology system	2011	22,503						9
10	walk-in cooler	2011	9,893						10
11	furnace	2011	7,952						11
12	Sprinkler system	2011	27,872						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,688,415	\$ 180,600		\$ 205,226	\$ 24,626	\$	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	\$1,189,343	\$171,178	\$171,178	\$		\$	71
72	Current Year Purchases	22,140						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,211,483	\$171,178	\$171,178	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$5,999,898	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$351,778	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$376,404	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$24,626	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: \$ 11,115
- 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. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.)

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

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		174		174
3	Classroom Wages (a)				
4	Clinical Wages (b)		13,456		13,456
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 13,630	\$	\$ 13,630
10	SUM OF line 9, col. 1 and 2 (e)	\$ 13,630			

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.)

	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	\$		\$ 354,933	\$		\$ 354,933	1
2	Licensed Speech and Language Development Therapist		hrs			147,458			147,458	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			394,410	34		394,444	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				726,791		726,791	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					54,447			54,447	13
14	TOTAL			\$		\$ 951,248	\$ 726,825		\$ 1,678,073	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,659	\$	1
2	Cash-Patient Deposits	8,669		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,432,423		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,740		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,186,053)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (730,562)	\$	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)	\$ (730,562)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 366,410	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,669		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	560,293		30
31	Accrued Taxes Payable (excluding real estate taxes)	729		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	111,950		35
	Other Current Liabilities(specify):			
36		8,441		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,056,492	\$	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)	\$ 1,056,492	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,787,054)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (730,562)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,858,361)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,858,361)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,307	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)	\$ 71,307	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)	\$ (1,787,054)	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,639,839	1
2	Discounts and Allowances for all Levels	(3,485,881)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,153,958	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,902,165	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,902,165	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	10,787	12
13	Barber and Beauty Care	49,601	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,335,723	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	40,402	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,436,513	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,253	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		140,102	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 140,102	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,640,991	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,134,426	31
32	Health Care	5,882,318	32
33	General Administration	2,442,066	33
	B. Capital Expense		
34	Ownership	1,067,208	34
	C. Ancillary Expense		
35	Special Cost Centers	39,342	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	other	4,324	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,569,684	40
41	Income before Income Taxes (line 30 minus line 40)**	71,307	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 71,307	43

* 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	1,904	1,972	\$ 69,197	\$ 35.09	1
2	Assistant Director of Nursing	3,584	3,971	104,074	26.21	2
3	Registered Nurses	10,040	10,435	278,889	26.73	3
4	Licensed Practical Nurses	47,997	49,941	1,085,319	21.73	4
5	CNAs & Orderlies	159,753	165,556	2,096,277	12.66	5
6	CNA Trainees	1,300	1,300	13,456	10.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,891	4,084	72,483	17.75	8
9	Activity Director					9
10	Activity Assistants	10,973	11,422	140,099	12.27	10
11	Social Service Workers	3,806	3,977	76,493	19.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,185	44,030	517,340	11.75	15
16	Dishwashers					16
17	Maintenance Workers	9,269	9,625	134,561	13.98	17
18	Housekeepers	23,139	24,134	260,920	10.81	18
19	Laundry	12,361	12,688	127,971	10.09	19
20	Administrator	1,900	2,080	98,548	47.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,559	16,290	345,811	21.23	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)	347,661	361,505	\$ 5,421,438 *	\$ 15.00	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		8,500		36
37	Medical Records Consultant		2,407		37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,540		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		5,090		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,537		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

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
Michael Schneider			\$ 98,548	Workers' Compensation Insurance	\$	135,112	IDPH License Fee	\$ 0
				Unemployment Compensation Insurance		63,669	Advertising: Employee Recruitment	12,038
				FICA Taxes		414,740	Health Care Worker Background Check	
				Employee Health Insurance		512,173	(Indicate # of checks performed)	2,330
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
						0		4,490
				Other Benefits		28,336	Dues & Subscriptions	15,850
				Central Office Allocation		82,781	License & Fees	4,027
							Central Office Allocation	11,559
							Less: Public Relations Expense	(4,490)
							Non-allowable advertising	(1,623)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 98,548					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$	1,236,811		\$ 44,181
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
			\$	Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Heritage Operations Group	Mgt		\$ 499,058					
			0					
			0					
							In-State Travel	
								2,884
								0
							Seminar Expense	1,563
							Central Office	(2,448)
							Entertainment Expense	()
							(agree to Sch. V,	
Legal adj to Zero			12,285				line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL	\$		TOTAL	\$ 1,999
			\$ 511,343					

* 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? 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 xx NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Barton Stone Home 46938 07/2007

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 101,288
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 12,444

(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. \$ _____

(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) 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

FACILITY		MEDICAID	STATE
Owned SNFs		NUMBER	LICENSE
			NUMBER
Heritage Health - South, LLC			48843
Heritage Health - Bloomington, LLC			48157
Heritage Health - Carlinville, LLC			48850
Heritage Health - Chillicothe, LLC			48868
Heritage Health - Dwight, LLC			50492
Heritage Health - Elgin, LLC			48132
Heritage Health - El Paso, LLC			48124
Heritage Health - Gibson City, LLC			48116
Heritage Health - Gillespie, LLC			48892
Heritage Health - LaSalle, LLC			51276
Heritage Health - Litchfield, LLC			48900
Heritage Health - Mendota, LLC			48108
Heritage Health - Minonk, LLC			48058
Heritage Health - Mt. Sterling, LLC			48041
Heritage Health - Mt. Zion, LLC			48074
Heritage Health - Normal, LLC			48082
Heritage Health - Pana, LLC			48884
Heritage Health - Peru, LLC			48090
Heritage Health - Staunton, LLC			48876
Heritage Health - Streator, LLC			48066
Barton W. Stone Jacksonville, LLC			48918
Danville Joint Ventures, LLC d/b/aColonial Manor			42168
Heritage Health - Springfield			41699
Cotillion Ridge			45138
Country Health			7880
Mason City Area NH			34256
St. Clara's Manor			50724
Vonderlieth Living Center			19976