

		FOR BHF USE					

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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: 0048843

Facility Name: Heritage Health-Beardstown

Address: 8306 St Lukes Dr Beardstown 62618
Number City Zip Code

County: Cass

Telephone Number: (217) 323-4055 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 7/2007

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 01/01/12 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)
(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 Heritage Health-Beardstown# 0048843 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	79	Skilled (SNF)	79	28,914	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	79	TOTALS	79	28,914	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,008	6,858	2,543	27,409	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,008	6,858	2,543	27,409	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.79%

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)

SLF

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 ☒

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 7/2007

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

YES ☐ Date _____ NO ☒

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

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 2,543Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	210,611	8,033		218,644		218,644	4,896	223,540			1
2	Food Purchase		247,304		247,304		247,304	36	247,340			2
3	Housekeeping	88,039	21,798		109,837		109,837		109,837			3
4	Laundry	60,786	11,109		71,895		71,895		71,895			4
5	Heat and Other Utilities			207,624	207,624		207,624	1,168	208,792			5
6	Maintenance	65,885	80,091	52,932	198,908		198,908	12,054	210,962			6
7	Other (specify):*											7
8	TOTAL General Services	425,321	368,335	260,556	1,054,212		1,054,212	18,154	1,072,366			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000	2,051	5,051			9
10	Nursing and Medical Records	1,301,860	119,400	8,324	1,429,584		1,429,584	1	1,429,585			10
10a	Therapy		337,892	393,404	731,296	(367,285)	364,011	187,469	551,480			10a
11	Activities	49,877	7,497		57,374		57,374		57,374			11
12	Social Services	47,510		3,659	51,169		51,169		51,169			12
13	CNA Training							817	817			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,399,247	464,789	408,387	2,272,423	(367,285)	1,905,138	190,338	2,095,476			16
	C. General Administration											
17	Administrative	62,220			62,220		62,220		62,220			17
18	Directors Fees											18
19	Professional Services			241,576	241,576		241,576	(218,044)	23,532			19
20	Dues, Fees, Subscriptions & Promotions			116,296	116,296	(70,272)	46,024	(19,090)	26,934			20
21	Clerical & General Office Expenses	141,299	16,534	9,743	167,576		167,576	222,395	389,971			21
22	Employee Benefits & Payroll Taxes			466,168	466,168		466,168	31,574	497,742			22
23	Inservice Training & Education			3,531	3,531		3,531	(1,532)	1,999			23
24	Travel and Seminar			7,621	7,621		7,621	(5,622)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,972	43,972		43,972	8,607	52,579			26
27	Other (specify):*			12,387	12,387		12,387	(12,000)	387			27
28	TOTAL General Administration	203,519	16,534	901,294	1,121,347	(70,272)	1,051,075	6,288	1,057,363			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,028,087	849,658	1,570,237	4,447,982	(437,557)	4,010,425	214,780	4,225,205			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							236,216	236,216			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,186	19,186		19,186	114,373	133,559			32
33	Real Estate Taxes							40,309	40,309			33
34	Rent-Facility & Grounds			459,900	459,900		459,900	(454,902)	4,998			34
35	Rent-Equipment & Vehicles			944	944		944	771	1,715			35
36	Other (specify):*											36
37	TOTAL Ownership			480,030	480,030		480,030	(63,233)	416,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					367,285	367,285		367,285			39
40	Barber and Beauty Shops		213		213		213		213			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					70,272	70,272		70,272			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		213		213	437,557	437,770		437,770			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,028,087	849,871	2,050,267	4,928,225		4,928,225	151,547	5,079,772			45

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

		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	(5,112)			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)	(1,532)			16
17	Non-Care Related Fees	(1,283)			17
18	Fines and Penalties				18
19	Entertainment	(8,584)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	5,282			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)			24
25	Fund Raising, Advertising and Promotional	(23,712)			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)	\$ (46,941)		\$	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)	198,488		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 198,488		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 151,547		37

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

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

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

Heritage Health-Beardstown

Report Period Beginning: ID# 0048843
Ending: 01/01/12
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		(1,283)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		5,282	19	22
23				23
24		(12,000)	27	24
25		(23,712)	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	(31,713)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Beardstown # 0048843 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	4,896	0	0	0	0	0	0	0	0	4,896	1
2	Food Purchase	0	0	36	0	0	0	0	0	0	0	0	36	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	1,168	0	0	0	0	0	0	0	0	1,168	5
6	Maintenance	0	0	12,054	0	0	0	0	0	0	0	0	12,054	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	18,154	0	0	0	0	0	0	0	0	18,154	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,051	0	0	0	0	0	0	0	0	2,051	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	187,469	0	0	0	0	0	0	0	0	0	187,469	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	817	0	0	0	0	0	0	0	0	817	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	187,469	2,869	0	0	0	0	0	0	0	0	190,338	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	5,282	(236,294)	12,968	0	0	0	0	0	0	0	0	(218,044)	19
20	Fees, Subscriptions & Promotions	(24,995)	0	5,905	0	0	0	0	0	0	0	0	(19,090)	20
21	Clerical & General Office Expenses	0	0	222,395	0	0	0	0	0	0	0	0	222,395	21
22	Employee Benefits & Payroll Taxes	0	0	31,574	0	0	0	0	0	0	0	0	31,574	22
23	Inservice Training & Education	(1,532)	0	0	0	0	0	0	0	0	0	0	(1,532)	23
24	Travel and Seminar	(8,584)	0	2,962	0	0	0	0	0	0	0	0	(5,622)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,607	0	0	0	0	0	0	0	0	8,607	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	TOTAL General Administration	(41,829)	(236,294)	284,411	0	0	0	0	0	0	0	0	6,288	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(41,829)	(48,825)	305,434	0	0	0	0	0	0	0	0	214,780	29

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	222,852	0	13,364	0	0	0	0	0	0	0	236,216	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,112)	119,177	0	308	0	0	0	0	0	0	0	114,373	32
33	Real Estate Taxes	0	40,275	0	34	0	0	0	0	0	0	0	40,309	33
34	Rent-Facility & Grounds	0	(459,900)	0	4,998	0	0	0	0	0	0	0	(454,902)	34
35	Rent-Equipment & Vehicles	0	0	0	771	0	0	0	0	0	0	0	771	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,112)	(77,596)	0	19,475	0	0	0	0	0	0	0	(63,233)	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)	(46,941)	(126,421)	305,434	19,475	0	0	0	0	0	0	0	151,547	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 Pg 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	187,469	187,469	2
3	V								3
4	V	19	Adjustment for Related Organization	236,294	Heritage Operations Group, LLC	0.00%		(236,294)	4
5	V								5
6	V	34	Adjustment for Related Organization	459,900	Heritage Manor Real Estate, LLC	0.00%		(459,900)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		40,275	40,275	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		114,404	114,404	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		222,852	222,852	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,773	4,773	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 696,194			\$ 569,773	\$ * (126,421)	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.		\$	\$ 4,896	15
16	V	2	Food Purchase					36	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,168	19
20	V	6	Maintenance					12,054	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,051	22
23	V	10	Nursing & Medical Records					1	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					817	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					12,968	31
32	V	20	Fees, Subscription, Promotions					5,905	32
33	V	21	Clerical & General Office Expenses					222,395	33
34	V	22	Employee Benefits & Payroll Taxes					31,574	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					2,962	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,607	38
39	Total			\$			\$ 0	\$ * 305,434	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					13,364	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					308	18
19	V	33	Real Estate Taxes					34	19
20	V	34	Rent-Facility & Grounds					4,998	20
21	V	35	Rent-Equipment & Vehicles					771	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	\$ * 19,475	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	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 Heritage Health-Beardstown # 0048843 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 Heritage Operations Group
Street Address box 3188
City / State / Zip Code Bloomington, IL 61701
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	Dietary	Beds	2,735	26	\$ 169,500	\$ 168,827	79	\$ 4,896	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	79	36	2
3	3	Housekeeping	Beds	2,735	26	0	0	79	0	3
4	4	Laundry	Beds	2,735	26	0	0	79	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	79	1,168	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	79	12,054	6
7	7	Other	Beds	2,735	26	0	0	79	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	79	2,051	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	79	1	9
10	11	Activities	Beds	2,735	26	0	0	79	0	10
11	12	Social Service	Beds	2,735	26	0	0	79	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	79	817	12
13	14	Program Transportation	Beds	2,735	26	0	0	79	0	13
14	15	Other	Beds	2,735	26	0	0	79	0	14
15	17	Administrative	Beds	2,735	26	0	0	79	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	79	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	79	12,968	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	79	5,905	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	79	222,395	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	79	31,574	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	79	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	79	2,962	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	79	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	79	8,607	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 305,434	25

Facility Name & ID Number Heritage Health-Beardstown # 0048843 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 Heritage Operations Group
Street Address box 3188
City / State / Zip Code Bloomington, IL 61701
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	27	Other	Beds	2,735	26	\$		79	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		79	13,364	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			79		3
4	32	Interest	Beds	2,735	26	10,650		79	308	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		79	34	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		79	4,998	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		79	771	7
8	36	Other	Beds	2,735	26			79		8
9	38	Medically Nec Transportation	Beds	2,735	26			79		9
10	39	Ancillary Service Centers	Beds	2,735	26			79		10
11	40	Barber and Beauty Shops	Beds	2,735	26			79		11
12	41	Coffee and Gift Shops	Beds	2,735	26			79		12
13	42	Other	Beds	2,735	26			79		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					\$ 674,220	\$		\$ 19,475	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		x	Mortgage			\$	2,128,292			\$	114,404	1	
2	Bank of America		x	Loan Fee Amort								4,773	2	
3													3	
4													4	
5													5	
	Working Capital													
6	Bank of America		xx	Working Capital								19,186	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	2,128,292			\$	138,363	9	
	B. Non-Facility Related*													
10	Interest Income											(5,112)	10	
11													11	
12	Allocated Corporate											308	12	
13													13	
14	TOTAL Non-Facility Related						\$				\$	(4,804)	14	
15	TOTALS (line 9+line14)						\$	2,128,292			\$	133,559	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.)	\$	40,275		2
3. Under or (over) accrual (line 2 minus line 1).	\$	40,275		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.	\$	40,275		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007		8	
	2008		9	
	2009		10	
	2010		11	
	2011	40,275	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
Heritage Health-Beardstown

COUNTY
Cass

FACILITY IDPH LICENSE NUMBER
0048843

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. 0301101201	nursing home	\$ 5,334.00	\$ 5,334.00
2. 0301101200		\$ 34,941.00	\$ 34,941.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 40,275.00	\$ 40,275.00

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: 24,196 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>25,000</u>	1
2					2
3	TOTALS			\$ <u>25,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	79				\$ 1,380,636	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Remodel facilitiy--Materials & Labor			1997	272,458					9
10										10
11	Nurse Call System			1997	1,500					11
12										12
13	Remodel facilitiy--Materials & Labor			1998	85,772					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	Door Alarm System			2000	2,727					27
28	A/C Compressor			2000	2,984					28
29	Compressor -- Walk-in Freezer			2000	2,586					29
30	Water Heater			2000	2,804					30
31										31
32										32
33	C/O Allocation					13,364			(13,364)	33
34	Book Depreciation					166,425		166,425		34
35										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	Recirculating Pump	2001	\$ 889	\$		\$	\$	\$	37
38	West entrance Door	2001	1,700						38
39									39
40	Door	2002	2,840						40
41	a/c unit	2002	15,900						41
42	Shower room Wall	2002	1,200						42
43	Cmpressor	2002	13,348						43
44									44
45	Sewer Relocation	2002	2,011						45
46									46
47	Sewer Relocation	2003	2,206						47
48	a/c units	2003	10,170						48
49									49
50	Disposer	2003	1,454						50
51	A/C Unit	2003	5,786						51
52	Rebuild Generator	2003	4,276						52
53									53
54	Exterior doors	2004	3,212						54
55	Shower room Remodel	2004	9,028						55
56	Landscapping	2004	3,030						56
57	Canopy	2004	570						57
58	Door	2004	1,068						58
59	A/C Unit	2004	7,326						59
60	Heat/Cool Units	2004	6,960						60
61	Carpet	2004	911						61
62	Compressor	2004	2,949						62
63	Chiller	2004	1,970						63
64	Drier Core	2004	953						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,851,224	\$ 179,789		\$ 166,425	\$ (13,364)	\$	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		\$ 1,851,224	\$ 179,789		\$ 166,425	\$ (13,364)		1
2	Shower Remodel	2005	7,273						2
3	Ansul System	2005	2,540						3
4									4
5									5
6	Interior rehab -- Labor and Materials	2005	28,299						6
7	Delayed Egress Magnet	2005	2,092						7
8	Panic Door Hardware	2005	2,125						8
9	Roof repair	2005	3,702						9
10									10
11									11
12	Door opener	2006	2,445						12
13	Wanderguard system	2006	2,267						13
14	Hot water heater	2006	13,771						14
15	Sidewalk	2006	4,928						15
16									16
17	Hvac	2006	17,853						17
18									18
19	Alarm system	2006	6,568						19
20	Gererator regulator	2006	1,727						20
21	Awning	2006	4,264						21
22	Closet door	2006	2,722						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)		\$ 1,953,800	\$ 179,789		\$ 166,425	\$ (13,364)		34

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

Facility Name & ID Number Heritage Health-Beardstown

0048843

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 1,953,800	\$ 179,789		\$ 166,425	\$ (13,364)		1
2	HVAC	2007	9,672						2
3	Chiller	2007	2,603						3
4									4
5	Post 6/30/07 capital review								5
6	Landscaping	2007	28,000						6
7	Water Heater	2007	21,682						7
8	Rooftop A/C	2007	205						8
9	Blinds	2007	845						9
10	Roof fans	2007	3,457						10
11	A/C	2007	12,487						11
12	Doors	2007	3,358						12
13	Generator	2007	39,004						13
14	Wall Heater	2007	3,384						14
15	Circulating pump	2007	896						15
16	Roof	2007	141,801						16
17	Capital report Adj	2007	(216,315)						17
18	HVAC Rooftop Unit	2008	148,000						18
19	Water Heater	2008	14,252						19
20	Heater Replacement	2008	4,008						20
21	Resident Room Remodel-- Painting, Lighting	2008	75,015						21
22	Hot Water Heater	2008	6,621						22
23	HVAC Units	2008	19,280						23
24	Electric Heater	2008	5,195						24
25	Capital report Adj	2008	(50,625)						25
26	Elevator	2009	9,873						26
27	Mixing valve	2009	3,715						27
28	Room painting	2009	6,065						28
29	Comdensor	2009	5,260						29
30	Lights	2009	4,055						30
31	Parking Lot	2009	83,790						31
32	Flooring	2009	18,770						32
33	Nurse Call System	2009	107,659						33
34	TOTAL (lines 1 thru 33)		\$ 2,465,812	\$ 179,789		\$ 166,425	\$ (13,364)		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		\$ 2,465,812	\$ 179,789		\$ 166,425	\$ (13,364)		1
2	Capital Report Adj	2009	(16,907)						2
3	Electric reheats	2010	4,647						3
4	HVAC units	2010	15,119						4
5	Insulation	2010	34,950						5
6	Parking Lot	2010	23,462						6
7	Nurse Call System	2010	183,517						7
8									8
9	Sprinkler	2011	63,196						9
10	Roof	2011	133,678						10
11	Heat/cool Units	2011	19,980						11
12	water tank	2011	7,503						12
13	Heat Panel	2011	5,003						13
14	sign	2011	22,000						14
15									15
16	Roof Replacement	2012	19,770						16
17	Water Heater	2012	13,243						17
18	Compressor	2012	14,538						18
19	Lighting: upgrade throughout facility including but not	2012	20,519						19
20	limited to, resident rooms, common areas, and offices								20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,030,030	\$ 179,789		\$ 166,425	\$ (13,364)		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	\$986,103	\$56,427	\$56,427	\$		\$	71
72	Current Year Purchases	10,214						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$996,317	\$56,427	\$56,427	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,051,347	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$236,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$222,852	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(13,364)	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?
16. Rental Amount for movable equipment: \$ 944 Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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.)

12345678										
	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	\$		\$ 144,072	\$		\$ 144,072	1
2	Licensed Speech and Language Development Therapist		hrs			61,270			61,270	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			158,365	304		158,669	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				337,588		337,588	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					29,697			29,697	13
14	TOTAL			\$		\$ 393,404	\$ 337,892		\$ 731,296	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	\$ 742	\$	1
2	Cash-Patient Deposits	14,503		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	939,204		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,414		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,237,972)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (248,109)	\$	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)	\$ (248,109)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 185,356	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,503		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	245,771		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,123		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>	112,240		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 562,993	\$	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)	\$ 562,993	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (811,102)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (248,109)	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,051,665)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,051,665)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	240,563	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)	\$ 240,563	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)	\$ (811,102)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health-Beardstown# 0048843Report Period Beginning: 01/01/12Ending: 12/31/12

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

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

		1	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,164,913	1
2	Discounts and Allowances for all Levels	(1,456,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,708,786	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,258,675	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,258,675	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	2,187	12
13	Barber and Beauty Care	1,528	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	54,198	16
17	Sale of Drugs	643,338	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19,377	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 720,628	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,112	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,112	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SLF	475,587	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 475,587	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,168,788	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,054,212	31
32	Health Care	2,272,423	32
33	General Administration	1,121,347	33
	B. Capital Expense		
34	Ownership	480,030	34
	C. Ancillary Expense		
35	Special Cost Centers	213	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,928,225	40
41	Income before Income Taxes (line 30 minus line 40)**	240,563	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 240,563	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,908	1,984	\$ 56,828	\$ 28.64	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,403	6,523	175,516	26.91	3
4	Licensed Practical Nurses	18,027	19,586	396,507	20.24	4
5	CNAs & Orderlies	61,225	65,347	623,501	9.54	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,006	2,174	49,508	22.77	8
9	Activity Director					9
10	Activity Assistants	3,678	4,130	49,877	12.08	10
11	Social Service Workers	1,948	2,033	47,510	23.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,842	19,200	210,611	10.97	15
16	Dishwashers					16
17	Maintenance Workers	4,142	4,590	65,885	14.35	17
18	Housekeepers	7,643	8,464	88,039	10.40	18
19	Laundry	4,866	4,992	60,786	12.18	19
20	Administrator	1,900	2,080	62,220	29.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,703	10,633	141,299	13.29	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)	141,291	151,736	\$ 2,028,087 *	\$ 13.37	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		3,000		36
37	Medical Records Consultant		1,470		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,300		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		3,659		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,429		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
Dennis Toohill			\$ 62,220	Workers' Compensation Insurance		\$ 40,287	IDPH License Fee	\$ 0
				Unemployment Compensation Insurance		65,358	Advertising: Employee Recruitment	5,767
				FICA Taxes		155,149	Health Care Worker Background Check (Indicate # of checks performed)	1,542
				Employee Health Insurance		200,016	Patient Background Checks	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		0		10,861
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,220	Other Benefits		5,358	Dues & Subscriptions	9,874
B. Administrative - Other				Central Office Allocation		31,574	License & Fees	5,129
Description			Amount				Central Office Allocation	5,905
			\$				Less: Public Relations Expense	(10,861)
							Non-allowable advertising	(1,283)
							Yellow page advertising (	)
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 497,742	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,934
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**	
C. Professional Services	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgt		\$ 236,294			\$	Out-of-State Travel	\$
			0					
Legal			5,282				In-State Travel	
								5,171
								211
							Seminar Expense	2,239
								(5,622)
							Entertainment Expense (	)
Legal adj to Zero			0				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,999
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 241,576	TOTAL		\$		

*** 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.

\$ 70,272

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.

\$ 997

(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	742				1,009		1,009	PETTY C	742
1010	CASH IN BANK					1,100		1,100	ACCTS R	939,204
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	939,204				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	35,414
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	35,414				1,310		1,310	SUPPLIES INVENTORY	
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY	
1300	FOOD INVENTORY					1,409		1,409	LAND	0
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU	0
1409	LAND	0				1,460				0
1450	FURNITURE & EQUIPMENT	0				1,475		1,475	CODE AI	0
1460	ACCUM DEPR-FURN & EQU	0				1,490		1,490	ACCUM I	0
1475	BUILDING & IMPROVEMEN	0				1,530		1,530	RESIDEN	14,503
1490	ACCUM DEPR-BUILDING	0				1,550		1,550	LOAN FE	0
1530	RESIDENT FUNDS	14,503				1,551		1,551	LOAN FEES ADDED	
1550	LOAN FEES	0				1,850		1,850	INTERCC	(1,237,972)
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN	(185,356)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-1,237,972				2,100		2,100	ACCRUE	(107,067)
2010	ACCOUNTS PAYABLE	-185,356				2,100		2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-107,067				2,110		2,110	ACCRUE	(138,704)
2110	ACCRUED VACATION PAY	-138,704				2,120		2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(5,123)
2125	FICA TAX PAYABLE	-5,123	-5,123	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 - CAFETERIA	
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 PAYMENT	(112,240)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL ESTATE	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-112,240		2,400	2,400 CURRENT PORTION OF LT DEBT	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO RESIDENTS	(14,503)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEBT	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED EARNINGS	1,051,665
2460	INCOME TAXES PAYABLE				net income	(240,563)
2512	DUE TO RESIDENTS	-14,503				
2600	MORTGAGE PAYABLE	0				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	1,051,665				
2970	PROFIT/LOSS FOR PERIOD	-240,563				
3007.1	PATIENT DAYS-PRIVATE	6,858				3,007

3007.2	PATIENT DAYS-IPA	18,008					3,007
3007.3	PATIENT DAYS-MEDICARE	2,543					3,007
3007.4	PATIENT DAYS-CONVERSION						3,007
3007.5	PATIENT DAYS-LICENSED						3,007
3007.6	PATIENT DAYS-TOTAL						3,007
3010	1 BASIC CHARGE-PRIVATE &	-4,133,981	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	-21,631	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	-643,338	0	0	0	0	3,101
3101	17 DRUGS-OTHER						3,110
3110	6 PT-PRIVATE	-1,258,675	0	0	0	0	3,111
3111	6 PT-IPA		0	0	0	0	3,112
3112	6 PT-MEDICARE PART A		0	0	0	0	3,113
3113	6 PT-MEDICARE PART B		0	0	0	0	3,140
3130	1 PUBLIC AID ASSESSMENT INC						3,150
3140	19 LABORATORY INCOME		0	0	0	0	3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0	3,152
3151	6 SPEECH/OT-IPA		0	0	0	0	3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0	3,160
3153	6 SPEECH/OT MED PART B						3,410
3410	2 IPA DISCOUNTS	1,456,127	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	-54,198		6	0	6	0	3,530
3530	13 BEAUTY SHOP	-1,528		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	-1,578		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-609		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-9,301		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-19,377		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	130,700	141,299	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	62,220	62,220	17	1	0	0	4,120
4115	VACATION & SICK - G&A	10,599		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	11,057	466,168	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	-5,699		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	16,534	16,534	21	2	0	0	4,275
4260	TELEPHONE	9,743	9,743	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	3,531	3,531	23	3	16	-1,532 **	4,280
4280	GENERAL TRAVEL	5,171	7,621	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	211		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	2,239		24	3	19	-8,584 ***	4,289
4290	HELP WANTED ADVERTISING	5,767	116,296	20	3	0	0 -70,272	4,290
4291	PROMOTIONAL ADVERTISING	12,851		20	3	25	-12,851	4,291
4292	PUBLIC RELATIONS	10,861		20	3	25	-10,861	4,292
4300	LICENSES & FEES	75,401		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	9,874		20	3	17	-1,283	4,310
4320	CONTRIBUTIONS	431		27	3	20	0	4,320
4350	PROFESSIONAL FEES	5,282	241,576	19	3	22	5,282	4,350
4355	MEDICAL DIRECTOR	3,000	3,000	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSULT	1,470		10	3	0	0	4,364
4363	PHARMACIST FEES	6,300		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,659	3,659	12	3	0	0	4,383
4370	TV RENTAL	-2,589		35	3	5	0	4,390
4380	INCOME TAXES		12,387	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,542		20	3	26	0	4,401
4400	PAYROLL TAXES	214,049		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	6,458		22	3	0	0	4,420
4410	GROUP INSURANCE	200,016		22	3	0	0	4,430
4420	LIABILITY INSURANCE	43,972	43,972	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	40,287		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	236,294		19	3	34	0 **	4,460
4460	BAD DEBTS	12,000		27	3	24	-12,000	4,461
4470	LOST ITEMS-RESIDENTS	-44		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	3,533	944	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	61,691	65,885	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,194		6	1	0	0	4,510
5130	ELECTRIC	198,170	207,624	5	3	0	0	4,600
5131	NATURAL GAS	0		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	9,454		5	3	0	0	5,130
5134	TRASH COLLECTION	12,763	52,932	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	20,447	80,091	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	59,644		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	40,169		6	3	0	0	5,140
5210	DIETARY WAGES	201,005	210,611	1	1	0	0	5,160
5220	DIETARY SICK & VAC	9,606		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	248,301	247,304	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,687	8,033	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,821		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	3,525		1	2	0	0	5,260
5295	MEAL CREDIT	-997		2	2	0	0	5,270
5310	LAUNDRY WAGES	57,999	60,786	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,787		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	2,357	11,109	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	8,752		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	83,076	88,039	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	4,963		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	6,193	21,798	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	15,605		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,301,860	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	169,849		10	1	0	0	6,020
6030	DON WAGES	56,828		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	5,667		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	380,866		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	15,641		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	598,582		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	24,919		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	46,829		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,679		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	23,039	119,400	10	2	0	0	7,281
6295	NURSING SUPPLIES	85,766		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	10,595		10	2	0	0	7,391
6490	NURSING OTHER	554	8,324	10	3	0	0	7,393
7280	DRUG PURCHASES	110,355	337,892	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	227,233		39	2			7,540
7380	LABORATORY SERVICES	29,697	393,404	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	47,489	49,877	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	2,388		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	7,497	7,497	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	158,365		39	3	0	0 ***	7,890
7660	PT SUPPLIES	304		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	45,681	47,510	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,829		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	144,072		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	61,270		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	213	213	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	459,900	459,900	34	3	0	0	

8120	INTEREST EXPENSE	19,186	19,186	32	3	14	-5,112	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-5,112		32	0	10	0	
9520	MISC NON-OPERATING INC	-475,587		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		4,447,526	4,928,225					
			480,699					

GRAND TOTALS

-240,563

-46,941

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	6,858	6,858
IPA	18,008	18,008
medicare	2,543	2,543
		27,409
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 6,858

3,007 PATIENT	18,008
3,007 PATIENT	2,543
	0

3,010 BASIC CI	(4,133,981)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(21,631)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(643,338)
	0

3,110 PHYSICAL	(1,258,675)
	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/OTH	0
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3,411 MEDICAL	0
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3,420 MEDICAL	1,407,715
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3,520 RENT IN	(54,198)
3,530 BEAUTY	(1,528)
	(1,578)
3,570 VENDING	(609)
3,590 EQUIPM	(9,301)
3,595 RESIDEN	(19,377)
3,600 MISC INC	0
4,110 G&A WA	130,700
4,111 ADMINIS	62,220
4,115 G&A PTC	10,599
4,120 EMPLOY	10,632
	0
4,130 EMPLOY	0
4,135 EMPLOY	(5,699)
4,250 OFFICE S	7,640
4,255 POSTAGI	1,946
4,260 TELEPHC	9,743
4,275 TRAININ	3,531
	144
4,280 GENERA	5,171
4,281 MEAL EX	211
4,285 EDUCAT	1,258
4,289 MEETING	981
4,290 HELP WA	5,767
4,291 PROMOT	12,851
4,292 PUBLIC I	10,861
4,300 LICENSE	75,401
4,310 DUES & F	9,874
4,320 CONTRIB	431
4,350 PROFESS	5,282
4,355 MEDICAL	3,000
	1,470
	6,300

4,364 SOCIAL S	3,659
4,370 TV RENT	(2,589)
4,383 BACKGR	1,542
4,390 OTHER T	0
4,400 PAYROL	214,049
4,401 PAYROL	6,458
4,410 GROUP I	200,016
4,420 LIABILIT	43,972
4,430 WORKM	38,635
4,435 W/C-FIRS	535
4,436 DRUG TE	973
4,450 MANAGI	236,294
4,460 BAD DEF	12,000
4,461 BAD DEF	48,412
4,470 LOST ITE	(44)
4,475 UNIFORM	425
4,486 SERVICE	17,693
4,490 MISC EX	30
4,496 MISC. M.	6,948
4,510 REAL ES	0
4,600 LEASED	3,533
5,110 MAINTEN	61,691
5,120 MAINTEN	4,194
5,130 ELECTRI	198,170
5,131 NATURA	0
5,133 WATER &	9,454
5,134 TRASH C	12,763
5,140 PROP/PL	20,447
5,160 GENERA	59,644
5,165 MAINTEN	22,476
5,210 DIETARY	201,005
5,220 DIETARY	9,606
5,248 FOOD PU	248,271

5,250 SUPPLIES	2,687
5,260 REPLACEMENTS	1,821
5,270 KITCHEN	3,525
5,295 MEAL IN	(997)
5,310 LAUNDRY	57,999
5,340 LAUNDRY	2,787
5,370 REPLACEMENTS	2,357
	27
5,390 SUPPLIES	8,725
5,410 HOUSEKEEPING	83,076
5,440 HOUSEKEEPING	4,963
5,480 SUPPLIES	6,193
5,490 SUPPLIES	15,605
6,020 RN WAGES	169,849
6,030 DONOR WAGES	56,828
6,035 ADONOR WAGES	0
6,040 RN PTO & OVERTIME	5,667
6,120 LPN WAGES	380,866
6,140 LPN PTO	15,641
6,220 AIDES WAGES	598,582
6,240 AIDES PTO	24,919
	0
	0
	0
	0
6,270 REHAB V	46,829
6,275 REHAB P	2,679
6,290 NURSING	23,039
6,295 NURSING	85,766
6,390 REPLACEMENTS	10,595
6,490 OTHER	554

7,280 DRUG PU	110,355
7,281 DRUG PU	227,233
7,380 LABORA	4,613
7,390 X-RAY S	2,951
	22,133
7,510 ACTIVIT	47,489
7,540 ACTIVIT	2,388
7,590 ACTIVIT	7,497
7,620 PHYSICA	158,365
7,660 P.T. SUP	304
7,710 SOCIAL S	45,681
7,720 SOCIAL S	1,829
7,730 SOCIAL S	0
7,740 OCCUPA	144,072
7,770 SPEECH '	61,270
7,820 BEAUTIC	0
	213
	0
8,120 INTERES	0
	19,186
8,130 DEPRECI	0
	0
9,510 INTERES	(5,112)
9,520 MISC NO	0
4,220	0
8,100	459,900
9,702	(475,587)
5,230	0
	<u>(240,563)</u>

Expenses Fixed Assets

FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
Owned SNFs		
Heritage Health - South, IL	20-5300302001	48843
Heritage Health - Bloomington, IL	20-3904134001	48157
Heritage Health - Carlinville, IL	20-5508113001	48850
Heritage Health - Chillicothe, IL	20-5412664001	48868
Heritage Health - Dwight, IL	20-5412784001	50492
Heritage Health - Elgin, IL	20-3902154001	48132
Heritage Health - El Paso, IL	20-3903447001	48124
Heritage Health - Gibson City, IL	20-3902572001	48116
Heritage Health - Gillespie, IL	20-5428620001	48892
Heritage Health - LaSalle, IL	27-3741988001	51276
Heritage Health - Litchfield, IL	20-5508096001	48900
Heritage Health - Mendota, IL	20-3904038001	48108
Heritage Health - Minonka, IL	20-3903980001	48058
Heritage Health - Mt. Sterling, IL	20-3903543001	48041
Heritage Health - Mt. Zion, IL	20-3903622001	48074
Heritage Health - Normal, IL	20-3903883001	48082
Heritage Health - Pana, IL	20-5508128001	48884
Heritage Health - Peru, IL	20-3902978001	48090
Heritage Health - Staunton, IL	20-5437628001	48876
Heritage Health - Streator, IL	20-3902216001	48066
Barton W. Stone Jackson, IL	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health - Springfield, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Springfield, IL	37-6064916001	7880
Mason City Area, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth Living Center, IL	37-0967671001	19976