

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048868

Facility Name: Heritage Health-Chillicothe

Address: 1028 Hillcrest Dr Chillicothe 61523
Number City Zip Code

County: Peoria

Telephone Number: (309) 274-2194 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 07/2007

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-Chillicothe# 0048868 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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,260</u>	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	<u>110</u>	TOTALS	<u>110</u>	<u>40,260</u>	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	<u>21,262</u>	<u>9,114</u>	<u>3,862</u>	<u>34,238</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,262</u>	<u>9,114</u>	<u>3,862</u>	<u>34,238</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.04%

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

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

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

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

none

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

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

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 07/2007

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 3,862Medicare 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	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	238,513	18,622		257,135		257,135	6,817	263,952		1
2	Food Purchase		233,474		233,474		233,474	50	233,524		2
3	Housekeeping	111,057	26,456		137,513		137,513		137,513		3
4	Laundry	39,909	13,467		53,376		53,376		53,376		4
5	Heat and Other Utilities			75,137	75,137		75,137	1,626	76,763		5
6	Maintenance	66,631	84,298	55,487	206,416		206,416	16,785	223,201		6
7	Other (specify):*										7
8	TOTAL General Services	456,110	376,317	130,624	963,051		963,051	25,278	988,329		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	2,856	14,856		9
10	Nursing and Medical Records	1,863,601	130,635	23,713	2,017,949		2,017,949	1	2,017,950		10
10a	Therapy		398,402	612,234	1,010,636	(429,691)	580,945	98,758	679,703		10a
11	Activities	62,591	7,070		69,661		69,661		69,661		11
12	Social Services	24,176	357	3,504	28,037		28,037		28,037		12
13	CNA Training	3,654	818		4,472		4,472	1,138	5,610		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,954,022	537,282	651,451	3,142,755	(429,691)	2,713,064	102,753	2,815,817		16
	C. General Administration										
17	Administrative	67,950			67,950		67,950		67,950		17
18	Directors Fees										18
19	Professional Services			274,990	274,990		274,990	(256,933)	18,057		19
20	Dues, Fees, Subscriptions & Promotions			170,507	170,507	(60,390)	110,117	(53,623)	56,494		20
21	Clerical & General Office Expenses	189,949	22,036	13,847	225,832		225,832	309,663	535,495		21
22	Employee Benefits & Payroll Taxes			573,589	573,589		573,589	43,963	617,552		22
23	Inservice Training & Education			5,574	5,574		5,574	(3,575)	1,999		23
24	Travel and Seminar			15,456	15,456		15,456	(13,457)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,426	56,426		56,426	11,984	68,410		26
27	Other (specify):*			206	206		206		206		27
28	TOTAL General Administration	257,899	22,036	1,110,595	1,390,530	(60,390)	1,330,140	38,022	1,368,162		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,668,031	935,635	1,892,670	5,496,336	(490,081)	5,006,255	166,053	5,172,308		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							262,528	262,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,735	26,735		26,735	170,423	197,158			32
33	Real Estate Taxes							74,419	74,419			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(474,840)	6,960			34
35	Rent-Equipment & Vehicles			10,529	10,529		10,529	1,074	11,603			35
36	Other (specify):*											36
37	TOTAL Ownership			519,064	519,064		519,064	33,604	552,668			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					429,691	429,691		429,691			39
40	Barber and Beauty Shops		43	9,417	9,460		9,460		9,460			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,390	60,390		60,390			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		43	9,417	9,460	490,081	499,541		499,541			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,668,031	935,678	2,421,151	6,024,860		6,024,860	199,657	6,224,517			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	(2,192)			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)	(3,575)			16
17	Non-Care Related Fees	(1,189)			17
18	Fines and Penalties				18
19	Entertainment	(17,581)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,719)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(60,656)			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)	\$ (94,912)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	294,569		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 294,569		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 199,657		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

Heritage Health-Chillicothe

Report Period Beginning: ID# 0048868

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
6		0	34
7			7
8			8
9		0	30
10			32
11			
12			
13		0	2
14			32
15		0	33
16			24
17		(1,189)	20
18			
19			24
20		0	27
21			
22		(9,719)	19
23			
24		0	27
25		(60,656)	20
26			
27			
28			
29			33
30			
31			
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	(71,564)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 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	6,817	0	0	0	0	0	0	0	0	6,817	1
2	Food Purchase	0	0	50	0	0	0	0	0	0	0	0	50	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	1,626	0	0	0	0	0	0	0	0	1,626	5
6	Maintenance	0	0	16,785	0	0	0	0	0	0	0	0	16,785	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	25,278	0	0	0	0	0	0	0	0	25,278	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,856	0	0	0	0	0	0	0	0	2,856	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	98,758	0	0	0	0	0	0	0	0	0	98,758	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	1,138	0	0	0	0	0	0	0	0	1,138	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	98,758	3,995	0	0	0	0	0	0	0	0	102,753	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,719)	(265,271)	18,057	0	0	0	0	0	0	0	0	(256,933)	19
20	Fees, Subscriptions & Promotions	(61,845)	0	8,222	0	0	0	0	0	0	0	0	(53,623)	20
21	Clerical & General Office Expenses	0	0	309,663	0	0	0	0	0	0	0	0	309,663	21
22	Employee Benefits & Payroll Taxes	0	0	43,963	0	0	0	0	0	0	0	0	43,963	22
23	Inservice Training & Education	(3,575)	0	0	0	0	0	0	0	0	0	0	(3,575)	23
24	Travel and Seminar	(17,581)	0	4,124	0	0	0	0	0	0	0	0	(13,457)	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	11,984	0	0	0	0	0	0	0	0	11,984	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(92,720)	(265,271)	396,013	0	0	0	0	0	0	0	0	38,022	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(92,720)	(166,513)	425,286	0	0	0	0	0	0	0	0	166,053	29

Summary B

12/31/12

												SUMMARY
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)
Depreciation	0	243,920	0	18,608	0	0	0	0	0	0	0	262,528
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0
Interest	(2,192)	172,187	0	428	0	0	0	0	0	0	0	170,423
Real Estate Taxes	0	74,372	0	47	0	0	0	0	0	0	0	74,419
Rent-Facility & Grounds	0	(481,800)	0	6,960	0	0	0	0	0	0	0	(474,840)
Rent-Equipment & Vehicles	0	0	0	1,074	0	0	0	0	0	0	0	1,074
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL Ownership	(2,192)	8,679	0	27,117	0	0	0	0	0	0	0	33,604
Ancillary Expense												
E. Special Cost Centers												
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(94,912)	(157,834)	425,286	27,117	0	0	0	0	0	0	0	199,657

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%	98,758	98,758	2
3	V								3
4	V	19	Adjustment for Related Organization	265,271	Heritage Operations Group, LLC	0.00%		(265,271)	4
5	V								5
6	V	34	Adjustment for Related Organization	481,800	Heritage Manor Real Estate, LLC	0.00%		(481,800)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		74,372	74,372	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		167,353	167,353	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		243,920	243,920	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,834	4,834	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 747,071			\$ 589,237	\$ * (157,834)	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.

YESNO

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.		\$	6,817	15
16	V	2	Food Purchase					50	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,626	19
20	V	6	Maintenance					16,785	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,856	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					1,138	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					18,057	31
32	V	20	Fees, Subscription, Promotions					8,222	32
33	V	21	Clerical & General Office Expenses					309,663	33
34	V	22	Employee Benefits & Payroll Taxes					43,963	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					4,124	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					11,984	38
39	Total			\$			\$ 0	\$ * 425,286	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					18,608	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					428	18
19	V	33	Real Estate Taxes					47	19
20	V	34	Rent-Facility & Grounds					6,960	20
21	V	35	Rent-Equipment & Vehicles					1,074	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	\$ * 27,117	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-Chillicothe# 0048868

Report Period Beginning:

01/01/12Ending: 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 ☐

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,735	26	\$ 169,500	\$ 168,827	110	\$ 6,817	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	110	50	2
3	3	Housekeeping	Beds	2,735	26	0	0	110	0	3
4	4	Laundry	Beds	2,735	26	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	110	1,626	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	110	16,785	6
7	7	Other	Beds	2,735	26	0	0	110	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	110	2,856	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	110	1	9
10	11	Activities	Beds	2,735	26	0	0	110	0	10
11	12	Social Service	Beds	2,735	26	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	110	1,138	12
13	14	Program Transportation	Beds	2,735	26	0	0	110	0	13
14	15	Other	Beds	2,735	26	0	0	110	0	14
15	17	Administrative	Beds	2,735	26	0	0	110	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	110	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	110	18,057	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	110	8,222	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	110	309,663	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	110	43,963	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	110	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	110	4,124	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	110	11,984	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 425,286	25

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,735	26	\$	\$	110	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		110	18,608	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			110		3
4	32	Interest	Beds	2,735	26	10,650		110	428	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		110	47	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		110	6,960	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		110	1,074	7
8	36	Other	Beds	2,735	26			110		8
9	38	Medically Nec Transportation	Beds	2,735	26			110		9
10	39	Ancillary Service Centers	Beds	2,735	26			110		10
11	40	Barber and Beauty Shops	Beds	2,735	26			110		11
12	41	Coffee and Gift Shops	Beds	2,735	26			110		12
13	42	Other	Beds	2,735	26			110		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	\$		\$ 27,117	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			\$	3,354,383			\$	167,353	1	
2	Bank of America		x	Loan Fee Amort								4,834	2	
3													3	
4													4	
5													5	
	Working Capital													
6	Bank of America		xx	Working Capital								26,735	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	3,354,383			\$	198,922	9	
	B. Non-Facility Related*													
10	Interest Income											(2,192)	10	
11													11	
12	Allocated Corporate											428	12	
13													13	
14	TOTAL Non-Facility Related						\$				\$	(1,764)	14	
15	TOTALS (line 9+line14)						\$	3,354,383			\$	197,158	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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$74,372	2
3. Under or (over) accrual (line 2 minus line 1).			\$74,372	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.			\$74,372	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		20078 20089 200910 201011 201174,37212	FOR BHF USE ONLY	
			13FROM R. E. TAX STATEMENT FOR 2011\$	13
			14PLUS APPEAL COST FROM LINE 5\$	14
			15LESS REFUND FROM LINE 6\$	15
			16AMOUNT 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-Chillicothe

COUNTY
Peoria

FACILITY IDPH LICENSE NUMBER
0048868

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.	<u>0529380001</u>	<u></u>	\$ <u>39.00</u>	\$ <u>74,372.00</u>
2.	<u>0529376016</u>	<u></u>	\$ <u>73,117.00</u>	\$ <u></u>
3.	<u>0529376017</u>	<u></u>	\$ <u>1,216.00</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>74,372.00</u></u>	\$ <u><u>74,372.00</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 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: 13,331 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>129,000</u>	1
2					2
3	TOTALS			\$ <u>129,000</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	110				\$ 3,301,403	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Awning		1998		2,334					9
10	Heritage Sign		1998		1,860					10
11	Chiller Replacement		1998		54,444					11
12										12
13	Interior Remodel--Materials		1999		154,576					13
14			1999							14
15	Interior Remodel--Professional Fees		1999		24,247					15
16										16
17	Water Heater controls		2000		1,347					17
18	Water Heater		2000		57,254					18
19	Door Locks		2000		1,997					19
20	Heat / Cool Fan		2000		1,598					20
21	Fire Alarm System		2000		4,400					21
22	Alzheimer Unit -- Professional Fees		2000		25,115					22
23	Interior Remodel--Materials (see attached)		2000		93,951					23
24	Interior Remodel--Labor (see attached)		2000		23,130					24
25	Interior Remodel--Professional Fees (see attached)		2000		5,762					25
26										26
27	Water Softener		2001		4,246					27
28	Boiler		2001		29,350					28
29	Door Holders		2001		654					29
30	Alzheimer Unit -- Professional Fees		2001		4,660					30
31										31
32										32
33	C/O Allocation					18,608			(18,608)	33
34	Book Depreciation					195,519		195,519		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	Carpet	2002	\$ 2,373	\$		\$	\$	\$	37
38	Compressor	2002	1,164						38
39	Compressor	2002	7,234						39
40	Windows	2002	1,722						40
41									41
42	Storge Tank	2003	737						42
43	In-sink Aerator	2003	810						43
44	Boiler	2003	16,393						44
45	Carpet	2003	2,839						45
46									46
47	Smoke detectors	2004	2,285						47
48	Dinning Room Waitress	2004	2,617						48
49	Parking Lot Sealcoat	2004	4,926						49
50	Boiler Pipe	2004	3,775						50
51	Auto Trans Switch	2004	16,847						51
52	Day Room	2004	1,778						52
53									53
54	Day Room	2005	8,753						54
55	Boiler	2005	19,619						55
56	Fire Alarm	2005	1,628						56
57	Resident Room Carpet	2005	698						57
58	Security System	2005	6,393						58
59	Breaker Replacement	2005	1,980						59
60	Condenser	2005	1,118						60
61	Roof	2005	188,466						61
62	Wiring	2005	820						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,087,303	\$ 214,127		\$ 195,519	\$ (18,608)	\$	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		\$ 4,087,303	\$ 214,127		\$ 195,519	\$ (18,608)	\$	1
2	Heat pump	2006	5,669						2
3	Boiler	2006	72,981						3
4	fire Alarm	2006	3,553						4
5	Roof	2006	1,300						5
6	Kitchen remodel	2006	4,623						6
7	Carpet	2006	1,139						7
8	Condensing Unit	2006	2,000						8
9	East Wing Dinning Room Remodel	2006	5,228						9
10									10
11	East Wing Remodel-- paint, floors	2007	23,281						11
12	Boiler	2007							12
13	Fire Alarm	2007							13
14	Generator	2007							14
15	Code Alert	2007	4,622						15
16	Fence	2007	3,089						16
17	Landscapping	2007							17
18	Parking Lot sealer	2007	5,000						18
19	Generator	2007	8,260						19
20	Heat pump	2007	21,969						20
21	Water Line	2007							21
22									22
23	East Wing Remodel-- paint, floors	2008	61,290						23
24	Sprinkler Backflow	2008	4,360						24
25	Heat pump	2008	16,046						25
26	Soiled Utility/Med Room	2008	2,622						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,334,335	\$ 214,127		\$ 195,519	\$ (18,608)	\$	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		\$ 4,334,335	\$ 214,127		\$ 195,519	\$ (18,608)	\$	1
2									2
3	Window replacements	2009	64,129						3
4									4
5	HVAC	2009	6,180						5
6	Heat Pump	2009	26,052						6
7	Nurse Call system	2009	226,889						7
8									8
9	Chiller	2010	3,429						9
10	Data Equipment Relocation	2010	2,658						10
11	Roof	2010	129,751						11
12	Paint, flooring & Labor Dining Room	2010	7,567						12
13									13
14	Sprinkler system	2011	77,240						14
15	Coil Unit	2011	3,744						15
16	Fluid cooler	2011	40,567						16
17	Exhaust fans	2011	7,141						17
18	Concrete walkway	2011	10,067						18
19	Remodel Adminstror's office	2011	3,200						19
20	Sign	2011	19,723						20
21	Boiler	2011	13,577						21
22									22
23	Lighting Upgrade	2012	7,959						23
24	Boiler	2012	15,051						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)		\$ 4,999,259	\$ 214,127		\$ 195,519	\$ (18,608)	\$	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		\$4,999,259	\$214,127		\$195,519	\$(18,608)		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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,999,259	\$214,127		\$195,519	\$(18,608)		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	\$736,468	\$48,401	\$48,401	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$736,468	\$48,401	\$48,401	\$		\$	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)	\$5,864,727	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$262,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$243,920	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(18,608)	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: \$ 10,529
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		818		818
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,654		3,654
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,472	\$	\$ 4,472
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,472		

(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.

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	

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	\$		\$ 192,838	\$		\$ 192,838	1
2	Licensed Speech and Language Development Therapist		hrs			116,443			116,443	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			270,994	670		271,664	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				397,732		397,732	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					31,959			31,959	13
14	TOTAL			\$		\$ 612,234	\$ 398,402		\$ 1,010,636	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	\$ 578	\$	1
2	Cash-Patient Deposits	17,467		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,305,280		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,875		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(480,748)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 851,452	\$	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)	\$ 851,452	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 227,459	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,467		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,661		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,013		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>	137,011		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 664,611	\$	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)	\$ 664,611	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 186,841	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 851,452	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (108,293)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (108,293)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	295,134	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)	\$ 295,134	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)	\$ 186,841	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,674,158	1
2	Discounts and Allowances for all Levels	(2,079,534)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,594,624	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,986,325	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,986,325	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	139	12
13	Barber and Beauty Care	7,964	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	726,651	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,099	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 736,853	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,192	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,192	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,319,994	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	963,051	31
32	Health Care	3,142,755	32
33	General Administration	1,390,530	33
	B. Capital Expense		
34	Ownership	519,064	34
	C. Ancillary Expense		
35	Special Cost Centers	9,460	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,024,860	40
41	Income before Income Taxes (line 30 minus line 40)**	295,134	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 295,134	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	1,898	2,024	\$ 61,019	\$ 30.15	1
2	Assistant Director of Nursing	2,139	2,308	66,290	28.72	2
3	Registered Nurses	9,333	9,773	260,087	26.61	3
4	Licensed Practical Nurses	20,172	21,904	520,301	23.75	4
5	CNAs & Orderlies	65,530	71,424	874,252	12.24	5
6	CNA Trainees			3,654		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,878	4,588	81,652	17.80	8
9	Activity Director					9
10	Activity Assistants	4,949	5,227	62,591	11.97	10
11	Social Service Workers	1,718	2,047	24,176	11.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,404	20,730	238,513	11.51	15
16	Dishwashers					16
17	Maintenance Workers	2,521	3,533	66,631	18.86	17
18	Housekeepers	9,373	9,910	111,057	11.21	18
19	Laundry	3,787	4,171	39,909	9.57	19
20	Administrator	1,950	2,080	67,950	32.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,823	9,971	189,949	19.05	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)	155,475	169,690	\$ 2,668,031 *	\$ 15.72	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,170		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,600		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		3,504		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,274		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	360	\$ 14,398		50
51	Licensed Practical Nurses	(71)	(2,500)		51
52	Certified Nurse Assistants/Aides	0	2,831		52
53	TOTAL (lines 50 - 52)	289	\$ 14,729		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Wade Ceis			\$ 67,950	Workers' Compensation Insurance		\$ 65,920	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance		53,713	Advertising: Employee Recruitment	36,108	
				FICA Taxes		204,104	Health Care Worker Background Check (Indicate # of checks performed _____)	1,770	
				Employee Health Insurance		200,781	Patient Background Checks		
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*		0		25,417	
				Other Benefits		49,071	Dues & Subscriptions	9,957	
				Central Office Allocation		43,963	License & Fees	1,626	
							Central Office Allocation	8,222	
							Less: Public Relations Expense	(25,417)	
							Non-allowable advertising	(1,189)	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,950	TOTAL (agree to Schedule V, line 22, col.8)		\$ 617,552	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 56,494
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
								13,010	
								34	
							Seminar Expense	2,412	
								(13,457)	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 1,999	
C. Professional Services									
Vendor/Payee	Type		Amount						
Heritage Operations Group	Mgt		\$ 265,271						
			0						
			0						
Legal adj to Zero			9,719						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 274,990						

*** 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. \$ 60,390

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. \$ 2,270

(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.

HFS 3745 (N-4-99)

IL478-2471

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	578				1,009		1,009	PETTY C	578
1010	CASH IN BANK					1,100		1,100	ACCTS R	1,305,280
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	1,305,280				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	8,875
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	8,875				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	17,467
1490	ACCUM DEPR-BUILDING	0				1,550		1,550	LOAN FE	0
1530	RESIDENT FUNDS	17,467				1,551		1,551	LOAN FEES ADDED	
1550	LOAN FEES	0				1,850		1,850	INTERCC	(480,748)
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN	(227,459)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-480,748				2,100		2,100	ACCRUE	(134,850)
2010	ACCOUNTS PAYABLE	-227,459				2,100		2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-134,850				2,110		2,110	ACCRUE	(142,811)
2110	ACCRUED VACATION PAY	-142,811				2,120		2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(5,013)	
2125	FICA TAX PAYABLE	-5,013	-5,013	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 PAYM	(137,011)	
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL ESTATE	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-137,011		2,400	2,400 CURRENT PORTION OF LT DEBT		
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO RESIDENTS	(17,467)	
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	108,293	
2460	INCOME TAXES PAYABLE				net income	(295,134)	
2512	DUE TO RESIDENTS	-17,467					
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	108,293					
2970	PROFIT/LOSS FOR PERIOD	-295,134					
3007.1	PATIENT DAYS-PRIVATE	9,114					3,007

3007.2	PATIENT DAYS-IPA	21,262						3,007
3007.3	PATIENT DAYS-MEDICARE	3,862						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-5,638,944	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	-29,839	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	-726,651	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,986,325	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,079,534	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	0		6	0	6	0	3,530
3530	13 BEAUTY SHOP	-7,964		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	-305		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	166		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-5,375		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-2,099		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	179,537	189,949	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	67,950	67,950	17	1	0	0	4,120
4115	VACATION & SICK - G&A	10,412		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	14,036	573,589	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	21,859		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	13,176		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	22,036	22,036	21	2	0	0	4,275
4260	TELEPHONE	13,847	13,847	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	5,574	5,574	23	3	16	-3,575 **	4,280
4280	GENERAL TRAVEL	13,010	15,456	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	34		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	2,412		24	3	19	-17,581 ***	4,289
4290	HELP WANTED ADVERTISING	36,108	170,507	20	3	0	0 -60,390	4,290
4291	PROMOTIONAL ADVERTISING	35,239		20	3	25	-35,239	4,291
4292	PUBLIC RELATIONS	25,417		20	3	25	-25,417	4,292
4300	LICENSES & FEES	62,016		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	9,957		20	3	17	-1,189	4,310
4320	CONTRIBUTIONS	200		27	3	20	0	4,320
4350	PROFESSIONAL FEES	9,719	274,990	19	3	22	-9,719	4,350
4355	MEDICAL DIRECTOR	12,000	12,000	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	2,170		10	3	0	0	4,364
4363	PHARMACIST FEES	6,600		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,504	3,504	12	3	0	0	4,383
4370	TV RENTAL	2,161		35	3	5	0	4,390
4380	INCOME TAXES		206	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,770		20	3	26	0	4,401
4400	PAYROLL TAXES	250,991		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	6,826		22	3	0	0	4,420
4410	GROUP INSURANCE	200,781		22	3	0	0	4,430
4420	LIABILITY INSURANCE	56,426	56,426	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	65,920		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	265,271		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	6		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	8,368	10,529	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	62,455	66,631	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,176		6	1	0	0	4,510
5130	ELECTRIC	44,325	75,137	5	3	0	0	4,600
5131	NATURAL GAS	17,792		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	13,020		5	3	0	0	5,130
5134	TRASH COLLECTION	8,666	55,487	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	35,321	84,298	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	48,977		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	46,821		6	3	0	0	5,140
5210	DIETARY WAGES	226,841	238,513	1	1	0	0	5,160
5220	DIETARY SICK & VAC	11,672		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	235,744	233,474	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,761	18,622	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,935		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	11,926		1	2	0	0	5,260
5295	MEAL CREDIT	-2,270		2	2	0	0	5,270
5310	LAUNDRY WAGES	37,980	39,909	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	1,929		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	6,979	13,467	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	6,488		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	105,232	111,057	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	5,825		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	9,815	26,456	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	16,641		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,863,601	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	245,273		10	1	0	0	6,020
6030	DON WAGES	61,019		10	1	0	0	6,030
6035	ADON	66,290		10	1	0	0	6,035
6040	RN SICK & VACATION	14,814		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	499,094		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	21,207		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	843,954		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	30,298		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	14,398		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	-2,500		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	2,831		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	3,654	3,654	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	818	818	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	76,512		10	1	0	0	6,390
6275	REHAB SICK & VAC	5,140		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	121,242	130,635	10	2	0	0	7,281
6295	NURSING SUPPLIES	643		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	8,750		10	2	0	0	7,391
6490	NURSING OTHER	214	23,713	10	3	0	0	7,393
7280	DRUG PURCHASES	212,294	398,402	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	185,438		39	2			7,540
7380	LABORATORY SERVICES	31,959	612,234	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	60,604	62,591	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	1,987		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	7,070	7,070	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	270,994		39	3	0	0 ***	7,890
7660	PT SUPPLIES	670		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	22,760	24,176	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,416		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	357	357	12	2	0	0	8,130
7740	OT FEE	192,838		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	116,443		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	9,417	9,417	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	43	43	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	481,800	481,800	34	3	0	0	

8120	INTEREST EXPENSE	26,735	26,735	32	3	14	-2,192	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-2,192		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		6,022,668	6,024,860					
			2,192					

GRAND TOTALS

-295,134

-94,912

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	9,114	9,114
IPA	21,262	21,262
medicare	3,862	3,862
		34,238

IPA BEDHOLDS

0

PP BEDHOLDS

0

PP CONVERS

0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 9,114

3,007 PATIENT	21,262
3,007 PATIENT	3,862
	0

3,010 BASIC CI	(5,638,944)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(29,839)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(726,651)
	0

3,110 PHYSICAL	(1,986,325)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

3,140 LABORATORY INCOME	
	0

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

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
3,411 MEDICAL	0

3,420 MEDICAL	1,977,397
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3,520 RENT IN	0
3,530 BEAUTY	(7,964)
	(305)
3,570 VENDIN	166
3,590 EQUIPM	(5,375)
3,595 RESIDEN	(2,099)
3,600 MISC INC	0
4,110 G&A WA	179,537
4,111 ADMINIS	67,950
4,115 G&A PTC	10,412
4,120 EMPLOY	14,614
	0
4,130 EMPLOY	21,859
4,135 EMPLOY	13,176
4,250 OFFICE S	13,561
4,255 POSTAGI	1,631
4,260 TELEPHC	13,847
4,275 TRAININ	5,574
	(18)
4,280 GENERA	13,010
4,281 MEAL EX	34
4,285 EDUCAT	1,108
4,289 MEETIN	1,304
4,290 HELP WA	36,108
4,291 PROMOT	35,239
4,292 PUBLIC I	25,417
4,300 LICENSE	62,016
4,310 DUES & F	9,957
4,320 CONTRIB	200
4,350 PROFESS	9,719
4,355 MEDICAL	12,000
	2,170
	6,600

4,364 SOCIAL S	3,504
4,370 TV RENT	2,161
4,383 BACKGR	1,770
4,390 OTHER T	0
4,400 PAYROL	250,991
4,401 PAYROL	6,826
4,410 GROUP I	200,781
4,420 LIABILIT	56,426
4,430 WORKM	63,949
4,435 W/C-FIRS	369
4,436 DRUG TE	1,620
4,450 MANAGI	265,271
4,460 BAD DEF	0
4,461 BAD DEF	102,137
4,470 LOST ITE	6
4,475 UNIFORM	(578)
4,486 SERVICE	19,751
4,490 MISC EX	45
4,496 MISC. M.	6,844
4,510 REAL ES	0
4,600 LEASED	8,368
5,110 MAINTEN	62,455
5,120 MAINTEN	4,176
5,130 ELECTRI	44,325
5,131 NATURA	17,792
5,133 WATER &	13,020
5,134 TRASH C	8,666
5,140 PROP/PL	35,321
5,160 GENERA	48,977
5,165 MAINTEN	27,070
5,210 DIETARY	226,841
5,220 DIETARY	11,672
5,248 FOOD PU	235,699

5,250 SUPPLIES	2,761
5,260 REPLACEMENTS	3,935
5,270 KITCHEN	11,926
5,295 MEAL IN	(2,270)
5,310 LAUNDRY	37,980
5,340 LAUNDRY	1,929
5,370 REPLACEMENTS	6,979
	0
5,390 SUPPLIES	6,488
5,410 HOUSEKEEPING	105,232
5,440 HOUSEKEEPING	5,825
5,480 SUPPLIES	9,815
5,490 SUPPLIES	16,641
6,020 RN WAGES	245,273
6,030 DONOR WAGES	61,019
6,035 ADONOR WAGES	66,290
6,040 RN PTO & OVERTIME	14,814
6,120 LPN WAGES	499,094
6,140 LPN PTO	21,207
6,220 AIDES WAGES	843,954
6,240 AIDES PTO	30,298
	14,398
	(2,500)
	2,831
	3,654
	818
	0
6,270 REHAB V	76,512
6,275 REHAB P	5,140
6,290 NURSING	121,242
6,295 NURSING	643
6,390 REPLACEMENTS	8,750
6,490 OTHER	214

7,280 DRUG PU	212,294
7,281 DRUG PU	185,438
7,380 LABORA	13,119
7,390 X-RAY S	6,685
	12,155
7,510 ACTIVIT	60,604
7,540 ACTIVIT	1,987
7,590 ACTIVIT	7,070
7,620 PHYSICA	270,994
7,660 P.T. SUP	670
7,710 SOCIAL S	22,760
7,720 SOCIAL S	1,416
7,730 SOCIAL S	357
7,740 OCCUPA	192,838
	0
7,770 SPEECH'	116,443
7,820 BEAUTIC	9,417
	43
	0
8,120 INTERES	0
	26,735
8,130 DEPRECI	0
	0
9,510 INTERES	(2,192)
9,520 MISC NO	0
4,220	0
8,100	481,800
9,702	0
5,230	0
	<u>(295,134)</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 Lutheran, IL	37-0967671001	19976