

		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: 0050492

Facility Name: Heritage Health-Dwight

Address: 300 E Mazon Ave Dwight 60420
Number City Zip Code

County: Livingston

Telephone Number: (815) 584-1240 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 07/2006

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(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-Dwight

0050492 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>92</u>	Skilled (SNF)	<u>92</u>	<u>33,672</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>92</u>	TOTALS	<u>92</u>	<u>33,672</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>15,881</u>	<u>9,816</u>	<u>3,424</u>	<u>29,121</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>15,881</u>	<u>9,816</u>	<u>3,424</u>	<u>29,121</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.48%

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 07/2006

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 3,424

Medicare 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.

Facility Name & ID Number Heritage Health-Dwight # 0050492 Report Period Beginning: 01/01/12 Ending: 12/31/12
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	263,362	14,444		277,806		277,806	5,702	283,508			1
2	Food Purchase		252,210		252,210		252,210	42	252,252			2
3	Housekeeping	120,438	27,493		147,931		147,931		147,931			3
4	Laundry	64,835	10,603		75,438		75,438		75,438			4
5	Heat and Other Utilities			104,317	104,317		104,317	1,360	105,677			5
6	Maintenance	87,771	67,203	41,189	196,163		196,163	14,038	210,201			6
7	Other (specify):*											7
8	TOTAL General Services	536,406	371,953	145,506	1,053,865		1,053,865	21,142	1,075,007			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600	2,389	11,989			9
10	Nursing and Medical Records	1,450,325	176,167	14,176	1,640,668		1,640,668	1	1,640,669			10
10a	Therapy		381,912	444,977	826,889	(396,133)	430,756	50,573	481,329			10a
11	Activities	101,638	7,862		109,500		109,500		109,500			11
12	Social Services	75,844		3,500	79,344		79,344		79,344			12
13	CNA Training							952	952			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,627,807	565,941	472,253	2,666,001	(396,133)	2,269,868	53,915	2,323,783			16
	C. General Administration											
17	Administrative	94,723			94,723		94,723		94,723			17
18	Directors Fees											18
19	Professional Services			254,437	254,437		254,437	(239,335)	15,102			19
20	Dues, Fees, Subscriptions & Promotions			130,203	130,203	(50,508)	79,695	(59,119)	20,576			20
21	Clerical & General Office Expenses	213,355	24,628	8,584	246,567		246,567	258,991	505,558			21
22	Employee Benefits & Payroll Taxes			519,177	519,177		519,177	36,769	555,946			22
23	Inservice Training & Education			6,274	6,274		6,274	(4,275)	1,999			23
24	Travel and Seminar			7,116	7,116		7,116	(5,117)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,093	42,093		42,093	10,023	52,116			26
27	Other (specify):*			28,315	28,315		28,315	(27,000)	1,315			27
28	TOTAL General Administration	308,078	24,628	996,199	1,328,905	(50,508)	1,278,397	(29,063)	1,249,334			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,472,291	962,522	1,613,958	5,048,771	(446,641)	4,602,130	45,994	4,648,124			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			206,347	206,347		206,347	15,563	221,910			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,244	23,244		23,244	(2,275)	20,969			32
33	Real Estate Taxes			49,214	49,214		49,214	39	49,253			33
34	Rent-Facility & Grounds			200,000	200,000		200,000	5,821	205,821			34
35	Rent-Equipment & Vehicles			11,872	11,872		11,872	898	12,770			35
36	Other (specify):*											36
37	TOTAL Ownership			490,677	490,677		490,677	20,046	510,723			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					396,133	396,133		396,133			39
40	Barber and Beauty Shops			5,523	5,523		5,523		5,523			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					50,508	50,508		50,508			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			5,523	5,523	446,641	452,164		452,164			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,472,291	962,522	2,110,158	5,544,971		5,544,971	66,040	5,611,011			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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	(2,633)			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)	(4,275)			16
17	Non-Care Related Fees	(1,134)			17
18	Fines and Penalties				18
19	Entertainment	(8,566)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,636)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,000)			24
25	Fund Raising, Advertising and Promotional	(64,862)			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)	\$ (117,106)		\$	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)	183,146		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 183,146		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 66,040		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-Dwight

ID# 0050492

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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		(1,134)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(8,636)	19	22
23				23
24		(27,000)	27	24
25		(64,862)	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	(101,632)		49

Summary B

12/31/12

[illegible]

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	50,573	50,573	2
3	V								3
4	V	19	Adjustment for Related Organization	245,801	Heritage Operations Group, LLC	0.00%		(245,801)	4
5	V								5
6	V	34	Adjustment for Related Organization		Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			\$ 245,801			\$ 50,573	\$ * (195,228)	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.		\$	5,702	15
16	V	2	Food Purchase					42	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,360	19
20	V	6	Maintenance					14,038	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,389	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					952	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					15,102	31
32	V	20	Fees, Subscription, Promotions					6,877	32
33	V	21	Clerical & General Office Expenses					258,991	33
34	V	22	Employee Benefits & Payroll Taxes					36,769	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					3,449	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					10,023	38
39	Total			\$			\$ 0	\$ * 355,695	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					15,563	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					358	18
19	V	33	Real Estate Taxes					39	19
20	V	34	Rent-Facility & Grounds					5,821	20
21	V	35	Rent-Equipment & Vehicles					898	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	\$ * 22,679	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-Dwight # 0050492 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	92	\$ 5,702	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	92	42	2
3	3	Housekeeping	Beds	2,735	26	0	0	92	0	3
4	4	Laundry	Beds	2,735	26	0	0	92	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	92	1,360	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	92	14,038	6
7	7	Other	Beds	2,735	26	0	0	92	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	92	2,389	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	92	1	9
10	11	Activities	Beds	2,735	26	0	0	92	0	10
11	12	Social Service	Beds	2,735	26	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	92	952	12
13	14	Program Transportation	Beds	2,735	26	0	0	92	0	13
14	15	Other	Beds	2,735	26	0	0	92	0	14
15	17	Administrative	Beds	2,735	26	0	0	92	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	92	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	92	15,102	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	92	6,877	18
19	21	Clerical & General Office Expense	Beds	2,735	26	7,699,360	7,229,609	92	258,991	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	92	36,769	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	92	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	92	3,449	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	297,962	0	92	10,023	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 355,695	25

Facility Name & ID Number Heritage Health-Dwight # 0050492 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	\$		92	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		92	15,563	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			92		3
4	32	Interest	Beds	2,735	26	10,650		92	358	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		92	39	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		92	5,821	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		92	898	7
8	36	Other	Beds	2,735	26			92		8
9	38	Medically Nec Transportation	Beds	2,735	26			92		9
10	39	Ancillary Service Centers	Beds	2,735	26			92		10
11	40	Barber and Beauty Shops	Beds	2,735	26			92		11
12	41	Coffee and Gift Shops	Beds	2,735	26			92		12
13	42	Other	Beds	2,735	26			92		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	\$		\$ 22,679	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	Van			\$	13,470			\$	880	1
2	Bank of America		x	Loan Fee Amort									2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		xx	Working Capital							22,364		6
7													7
8													8
9	TOTAL Facility Related						\$	13,470			\$	23,244	9
	B. Non-Facility Related*												
10	Interest Income										(2,633)		10
11													11
12	Allocated Corporate										358		12
13													13
14	TOTAL Non-Facility Related						\$				\$	(2,275)	14
15	TOTALS (line 9+line14)						\$	13,470			\$	20,969	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.		\$	51,387	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.)		\$	49,074	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,313)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	51,527	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.		\$	49,214	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	41,614	8	
		2008	51,328	9	
		2009	44,054	10	
		2010	48,641	11	
		2011	49,214	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

- 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	<u>Heritage Health-Dwight</u>	COUNTY	<u>Livingston</u>
---------------	-------------------------------	--------	-------------------

FACILITY IDPH LICENSE NUMBER 0050492

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.	050504483011		\$ 1,100.00	\$ 1,100.00
2.	050504483002		\$ 1,614.00	\$ 1,614.00
3.	050504483001		\$ 46,360.00	\$ 46,360.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 49,074.00	\$ 49,074.00

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?

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

34,102

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

none

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	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	92				\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1992 Improvements		1992		8,456					9
10	1993 Improvements		1993		586,243					10
11	1994 Improvements		1994		12,874					11
12	1995 Improvements		1995		496					12
13	Water Heater		1996		7,350					13
14	Interior Rehab (see attached)		1997		118,804					14
15	Garbage Disposal		1997		983					15
16										16
17	Parking Lot		1998		2,717					17
18	Interior Rehab		1998		17,242					18
19										19
20	Alarm Repair/Replacement		1999		1,120					20
21	Air Conditioning Unit		1999		2,461					21
22	Shower Room Repair		1999		6,345					22
23										23
24	Fire Dampers		2000		1,290					24
25	Boiler		2000		1,540					25
26										26
27	Water Heater		2001		7,200					27
28	Window Replacements		2001		4,437					28
29	Flooring -- Kitchen		2001		604					29
30	Code Alert System		2001		933					30
31	Motor Reolacement--A/C		2001		1,398					31
32										32
33	C/O Allocation					15,563			(15,563)	33
34	Book Depreciation					123,371		123,371		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

Facility Name & ID Number Heritage Health-Dwight

0050492

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	
37	A/C compressor	2002	\$ 582	\$		\$	\$	\$	37
38	Boiler Tubing	2002	11,208						38
39	Backflow preventor	2002	2,803						39
40	Wallcoverings	2002	21,813						40
41	Compressor	2002	1,175						41
42	Rooftop A/C unit	2002	20,169						42
43	adustment	2002	(9,766)						43
44	Wallcoverings	2003	1,528						44
45	Rooftop A/C unit	2003							45
46	Exterior Doors	2003	3,121						46
47	30 Gallon Tank	2003	1,056						47
48	Compressor	2003	1,839						48
49	Walk in Freezer	2003	3,301						49
50	Disposal	2003	771						50
51									51
52	Fire Supression System	2004	1,523						52
53	Pump	2004	714						53
54	Boiler	2004	13,085						54
55	Water Softener	2004	1,467						55
56	Parking Lot Sealant	2004	2,800						56
57	Laundry drain	2004	2,350						57
58									58
59	Motor --Circulator	2005	1,674						59
60	Water Heater	2005	10,113						60
61	Kitchen Door	2005	240						61
62	A/C compressor	2005	175						62
63	Generator Panel	2005	833						63
64	Closet Rehab	2005	1,137						64
65	Exterior Lights	2005	127						65
66	A/C compressor	2005	4,597						66
67	Kitchen Water Heater	2005	1,059						67
68	Sidewalks	2005	7,450						68
69	Boiler Repair	2005	1,967						69
70	TOTAL (lines 4 thru 69)		\$ 893,404	\$ 138,934		\$ 123,371	\$ (15,563)	\$	70

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

Facility Name & ID Number Heritage Health-Dwight

0050492

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 893,404	\$ 138,934		\$ 123,371	\$ (15,563)	\$	1
2	Inline exhaust	2006	2,465						2
3	A/C compressor	2006	8,093						3
4	Exhaust fan	2006	2,435						4
5	Roof	2006	97,870						5
6	Dayroom -- paint	2006							6
7	Sewer	2006	2,260						7
8									8
9	Dayroom -- paint	2007	10,633						9
10	In-sink Erator	2007	895						10
11	Rooftop A/C	2007	12,269						11
12	Window	2007	583						12
13	Water Softener	2007	17,709						13
14	Water Heater	2007	11,668						14
15	Exterior Panting	2007	14,215						15
16	Water Heater	2007	12,140						16
17	adjustments	2007	(3,034)						17
18	Boiler	2008	6,030						18
19	Kitchen/Restroom Upgrade	2008	3,989						19
20	HVAC Unit	2008	13,845						20
21	Resident Room/Corridor Painting	2008	4,275						21
22									22
23	Shower	2009	33,402						23
24	Sidewalk	2009	3,860						24
25	Dining room rehab: flooring, wallcovering & labor	2009	16,336						25
26	Nurse Call system	2009	257,238						26
27									27
28									28
29	Fire Alarm	2010	47,091						29
30	Storage Shed/garage	2010	40,207						30
31	Asphalt Drive/parking lot	2010	35,536						31
32	Facility Remodel	2010	813,560						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,358,974	\$ 138,934		\$ 123,371	\$ (15,563)	\$	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,358,974	\$ 138,934		\$ 123,371	\$ (15,563)	\$	1
2								2
3 Landscapping	2011	17,207						3
4 Facility Remodel	2011	99,642						4
5 Rooftop A/C	2011	16,547						5
6								6
7 water heater	2012	13,186						7
8 compressor	2012	6,742						8
9 Lighting Upgrade	2012	4,961						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)		\$ 2,517,259	\$ 138,934		\$ 123,371	\$ (15,563)	\$	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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,517,259	\$ 138,934		\$ 123,371	\$ (15,563)	\$	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)		\$ 2,517,259	\$ 138,934		\$ 123,371	\$ (15,563)	\$	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	\$851,109	\$82,976	\$82,976	\$		\$	71
72	Current Year Purchases	6,158						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$857,267	\$82,976	\$82,976	\$		\$	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)				\$3,374,526
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$221,910
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$206,347
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$(15,563)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: Dwight Continental Manor.
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:		92		\$ 200,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 200,000			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☒ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 11,872
- 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

		ALLOCATION OF COSTS		(d)	
		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)	\$			

(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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 188,732	\$		\$ 188,732	1
2	Licensed Speech and Language Development Therapist		hrs			29,577			29,577	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			212,447	0		212,447	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				381,912		381,912	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,221			14,221	13
14	TOTAL			\$		\$ 444,977	\$ 381,912		\$ 826,889	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	\$ 1,751	\$	1
2	Cash-Patient Deposits	12,414		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,021,111		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,045		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,074,378)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,008,057)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,565,663		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	919,358		16
17	Accumulated Depreciation (book methods)	(1,732,499)		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)	\$ 1,752,522	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 744,465	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 190,320	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,414		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	203,709		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,335		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,527		32
33	Accrued Interest Payable	46		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Assessment Tax	117,345		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 581,696	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	13,470		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)	\$ 13,470	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 595,166	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 149,299	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 744,465	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$116,840	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$116,840	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,459	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)	\$32,459	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)	\$149,299	24 *

* This must agree with page 17, line 47.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,089,574	1
2	Discounts and Allowances for all Levels	(1,749,394)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,340,180	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,487,451	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,487,451	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	2,572	12
13	Barber and Beauty Care	8,433	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	727,688	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,292	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 745,985	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,633	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,633	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,181	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,181	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,577,430	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,053,865	31
32	Health Care	2,666,001	32
33	General Administration	1,328,905	33
	B. Capital Expense		
34	Ownership	490,677	34
	C. Ancillary Expense		
35	Special Cost Centers	5,523	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)*	\$ 5,544,971	40
41	Income before Income Taxes (line 30 minus line 40)**	32,459	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 32,459	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	1,856	2,024	\$ 61,146	\$ 30.21	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	12,814	13,733	365,353	26.60	3
4	Licensed Practical Nurses	7,180	7,760	159,705	20.58	4
5	CNAs & Orderlies	59,169	63,314	735,997	11.62	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,056	7,327	128,124	17.49	8
9	Activity Director					9
10	Activity Assistants	7,490	7,983	101,638	12.73	10
11	Social Service Workers	4,262	4,581	75,844	16.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,720	24,822	263,362	10.61	15
16	Dishwashers					16
17	Maintenance Workers	6,062	6,515	87,771	13.47	17
18	Housekeepers	9,742	2,192	120,438	54.94	18
19	Laundry	5,978	6,432	64,835	10.08	19
20	Administrator	1,950	2,080	94,723	45.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,196	11,128	213,355	19.17	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	159,891	\$ 2,472,291 *	\$ 15.46	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		9,600		36
37	Medical Records Consultant		914		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,520		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		3,500		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,534		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHeritage Health-Dwight# 0050492Report Period Beginning:01/01/12Ending:12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Randy Provence			\$ 94,723
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,723

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	\$ 245,801
		0
		0
Legal adj to Zero		8,636
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 254,437

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 51,478	
Unemployment Compensation Insurance	54,032	
FICA Taxes	189,130	
Employee Health Insurance	190,473	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
	0	
Other Benefits	34,064	
Central Office Allocation	36,769	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 555,946

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$ 0	
Advertising: Employee Recruitment	4,254	
Health Care Worker Background Check (Indicate # of checks performed)	2,625	
Patient Background Checks		
	17,527	
Dues & Subscriptions	6,642	
License & Fees	1,312	
Central Office Allocation	6,877	
Less: Public Relations Expense	(17,527)	
Non-allowable advertising	(1,134)	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,576

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	4,513
	551
Seminar Expense	2,052
	(5,117)
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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

Line10

(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?

YESxNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOx

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.

\$50,508

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.

\$1,869

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name:

Sulaski & Webb

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

yes

Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount		
1009	PETTY CASH	1,751				1,009		1,009	PETTY CASH 1,751
1010	CASH IN BANK					1,100		1,100	ACCTS RECEIV-PF 1,021,111
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBL
1100	ACCOUNTS RECEIVABLE	1,021,111				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 INSURAI 31,045
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	31,045				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	FURNITURE & EQ 919,358
1409	LAND	0				1,460			(584,725)
1450	FURNITURE & EQUIPMENT	919,358				1,475		1,475	CODE ALERT MOI 2,565,663
1460	ACCUM DEPR-FURN & EQU	-584,725				1,490		1,490	ACCUM DEPR-BUI (1,147,774)
1475	BUILDING & IMPROVEMEN	2,565,663				1,530		1,530	RESIDENT FUNDS 12,414
1490	ACCUM DEPR-BUILDING	-1,147,774				1,550		1,550	LOAN FEES 0
1530	RESIDENT FUNDS	12,414				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	0				1,850		1,850	INTERCOMPANY (2,074,378)
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUNTS PAYA (190,320)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	-2,074,378				2,100		2,100	ACCRUED PAYRO (70,647)
2010	ACCOUNTS PAYABLE	-190,320				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-70,647				2,110		2,110	ACCRUED PTO PA (133,062)
2110	ACCRUED VACATION PAY	-133,062				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAXES PAY/	(6,335)
2125	FICA TAX PAYABLE	-6,335	-6,335	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 EMPLOYEEE INSURANCE REI	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUED INTERE	(46)
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYMENTS P/	(117,345)
2300	ACCRUED INTEREST PAYA	-46		2,350	2,350 REAL ESTATE TAX	(51,527)
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-117,345		2,400	2,400 CURRENT PORTION OF LT DE	
2350	REAL ESTATE TAX PAYAB	-51,527		2,512	2,512 DUE TO RESIDENT	(12,414)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE BANK #	(13,470)
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 DE	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED EARNI	(116,840)
2460	INCOME TAXES PAYABLE				net income	(32,459)
2512	DUE TO RESIDENTS	-12,414				
2600	MORTGAGE PAYABLE	-13,470				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-116,840				
2970	PROFIT/LOSS FOR PERIOD	-32,459				
3007.1	PATIENT DAYS-PRIVATE	9,816				

3007.2	PATIENT DAYS-IPA	15,881				
3007.3	PATIENT DAYS-MEDICARE	3,424				
3007.4	PATIENT DAYS-CONVERSION					
3007.5	PATIENT DAYS-LICENSED					
3007.6	PATIENT DAYS-TOTAL					
3010	1 BASIC CHARGE-PRIVATE &	-5,027,121	0	0	0	0
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0
3020	1 BASIC CHARGE-IPA	0	0	0	0	0
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0
3035	4 DAY CARE/HOME CARE		0	0	0	0
3040	1 LIGHT NURSING CARE	0	0	0	0	0
3050	1 MEDIUM NURSING CARE		0	0	0	0
3060	1 HEAVY NURSING CARE		0	0	0	0
3061	1 SKILLED NURSING CARE					
3080	1 NURSING SUPPLIES-PRIVA	-48,702	0	0	0	0
3081	1 NURSING SUPPLIES-IPA		0	0	0	0
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0
3083	1 NURSING SUPPLIES MED PT B					
3100	17 DRUGS	-727,688	0	0	0	0
3101	17 DRUGS-OTHER					
3110	6 PT-PRIVATE	-1,487,451	0	0	0	0
3111	6 PT-IPA		0	0	0	0
3112	6 PT-MEDICARE PART A		0	0	0	0
3113	6 PT-MEDICARE PART B		0	0	0	0
3130	1 PUBLIC AID ASSESSMENT INC					
3140	19 LABORATORY INCOME		0	0	0	0
3150	6 SPEECH/OT-PRIVATE		0	0	0	0
3151	6 SPEECH/OT-IPA		0	0	0	0
3152	6 SPEECH/OT-MED PART A		0	0	0	0
3153	6 SPEECH/OT MED PART B					
3410	2 IPA DISCOUNTS	1,749,394	0	0	0	0
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0
3420	2 MEDICARE DISCOUNTS		0	0	0	0

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	
3520	16 RENT INCOME	0		6	0	6	0	
3530	13 BEAUTY SHOP	-8,433		0	0	0	0	
3560	12 ACTIVITY FUND INCOME	-517		0	0	0	0	
3570	12 VENDING INCOME/EXPENSE	-2,055		0	0	0	0	
3580	12 MANAGEMENT FEES			0	0	0	0	
3590	1 EQUIPMENT RENTAL	-13,751		0	0	0	0	
3595	21 RESIDENT TRANSPORTATION	-7,292		0	0	0	0	
3600	21 MISC INCOME	0		0	0	0	0	
4110	GENERAL & ADMINISTRATIVE WAGES	198,699	213,355	21	1	17	0	
4111	ADMINISTRATOR WAGES	94,723	94,723	17	1	0	0	
4115	VACATION & SICK - G&A	14,656		21	1	0	0	
4120 4475	EMPLOYEE BENEFITS	14,275	519,177	22	3	0	0	
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	
4130	EMPLOYEE SCHOLORSHIP	23,103		21	1	0	0	
4135	EMPLOYEE SCHOLORSHIP	-3,314		23	3	0	0	
4220	DIRECTORS FEES	0	0	18	3	0	0	
4250 4255	OFFICE SUPPLIES	24,628	24,628	21	2	0	0	
4260	TELEPHONE	8,584	8,584	21	3	0	0	
4275	TRAINING & EMPLOYEE DEVELOPMENT	6,274	6,274	23	3	16	-4,275	**
4280	GENERAL TRAVEL	4,513	7,116	24	3	16	0	
4281	MEAL EXPENSE FOR TRAVEL	551		24	3	19	0	
4285	EDUCATION & SEMINAR	2,052		24	3	19	-8,566	***
4290	HELP WANTED ADVERTISING	4,254	130,203	20	3	0	0	-50,508
4291	PROMOTIONAL ADVERTISING	47,335		20	3	25	-47,335	
4292	PUBLIC RELATIONS	17,527		20	3	25	-17,527	
4300	LICENSES & FEES	51,820		20	3	17	0	
4310	DUES & SUBSCRIPTIONS	6,642		20	3	17	-1,134	
4320	CONTRIBUTIONS	0		27	3	20	0	
4350	PROFESSIONAL FEES	8,636	254,437	19	3	22	-8,636	
4355	MEDICAL DIRECTOR	9,600	9,600	9	3	0	0	
4360	UTILIZATION REVIEW	0		10	3	0	0	
4361	OTHER PHYSICIAN FEES			39	3	0	0	

4362	MEDICAL RECORDS CONSI	914		10	3	0	0
4363	PHARMACIST FEES	5,520		10	3	0	0
4364	SOC SERV/ACT CONSULT	3,500	3,500	12	3	0	0
4370	TV RENTAL	9,406		35	3	5	0
4380	INCOME TAXES		28,315	27	3	26	0
4383	BACKGROUND CHECKS	2,625		20	3	26	0
4400	PAYROLL TAXES	233,954		22	3	0	0
4401	PAYROLL TAXES ADMINIS	9,208		22	3	0	0
4410	GROUP INSURANCE	190,473		22	3	0	0
4420	LIABILITY INSURANCE	42,093	42,093	26	3	0	0
4425	INSURANCE-OWNERS			22	3	21	0
4430	WORKMENS COMP INSUR/	51,478		22	3	0	0
4450	CENTRAL OFFICE FEES	245,801		19	3	34	0 **
4460	BAD DEBTS	27,000		27	3	24	-27,000
4470	LOST ITEMS-RESIDENTS	1,315		27	3	0	
4490	MISCELLANEOUS	0		27	3	0	0
4510	REAL ESTATE TAXES	49,214	49,214	33	3	0	0
4600	LEASED EQUIPMENT	2,466	11,872	35	3	16	0
5110	MAINTENANCE SALARIES	84,192	87,771	6	1	0	0
5120	MAINTENANCE SICK & VA	3,579		6	1	0	0
5130	ELECTRIC	39,581	104,317	5	3	0	0
5131	NATURAL GAS	20,068		5	3	0	0
5132	HEATING & DEISEL OIL			5	3	0	0
5133	WATER & SEWER	44,668		5	3	0	0
5134	TRASH COLLECTION	10,945	41,189	6	3	0	0
5140	PROPERTY PLANT REPLAC	14,026	67,203	6	2	0	0
5160	GENERAL REPAIR & MAIN'	53,177		6	2	0	0
5165	MAINTENANCE CONTRAC'	30,244		6	3	0	0
5210	DIETARY WAGES	251,456	263,362	1	1	0	0
5220	DIETARY SICK & VAC	11,906		1	1	0	0
5240	SALES TAX			2	3	13	0
5248	FOOD PURCHASES	254,079	252,210	2	2	0	0
5250	SUPPLIES-DISHWASHING	2,712	14,444	1	2	0	0

5260	DIETARY REPLACEMENT	3,998		1	2	0	0
5270	KITCHEN SUPPLIES-PAPER	7,734		1	2	0	0
5295	MEAL CREDIT	-1,869		2	2	0	0
5310	LAUNDRY WAGES	61,072	64,835	4	1	0	0
5340	LAUNDRY SICK & VAC	3,763		4	1	0	0
5370	LAUNDRY REPLACEMENT	4,892	10,603	4	2	0	0
5380	LAUNDRY REIMBURSEMENT			4	3	0	0
5390	LAUNDRY SUPPLIES	5,711		4	2	0	0
5410	HOUSEKEEPING WAGES	114,732	120,438	3	1	0	0
5440	HOUSEKEEPING SICK & VAC	5,706		3	1	0	0
5480	HOUSEKEEPING SUPPLIES	9,757	27,493	3	2	0	0
5490	HOUSEKEEPING SUPPLIES-	17,736		3	2	0	0
6010	RN WAGES-MEDICARE		1,450,325	10	1	0	0
6020	RN WAGES-NON MEDICAR	349,701		10	1	0	0
6030	DON WAGES	61,146		10	1	0	0
6035	ADON	0		10	1	0	0
6040	RN SICK & VACATION	15,652		10	1	0	0
6110	LPN WAGES-MEDICARE	153,522		10	1	0	0
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0
6130	LPN WAGES OTHER			10	1	0	0
6140	LPN SICK & VACATION	6,183		10	1	0	0
6210	AIDE WAGES-MEDICARE			10	1	0	0
6220	AIDE WAGES-NON MEDICAL	717,441		10	1	0	0
6230	WARD CLERKS			10	1	0	0
6240	AIDE VACATION & SICK	18,556		10	1	0	0
6245	CONTRACT NURSES-RN	0		10	3	0	0
6246	CONTRACT NURSES-LPN	0		10	3	0	0
6247	CONTRACT NURSES-AIDES	0		10	3	0	0
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0
6260	NURSE AIDE TRAINING RE	-1,896		0	0	0	0
6270	REHAB WAGES	120,910		10	1	0	0
6275	REHAB SICK & VAC	7,214		10	1	0	0

6280	NURSING DEPT EDUCATION			23	3	0	0
6290	NURSING SUPPLIES	107,002	176,167	10	2	0	0
6295	NURSING SUPPLIES	53,928		10	2	0	0
6390	REPLACEMENT-NURSING	15,237		10	2	0	0
6490	NURSING OTHER	7,742	14,176	10	3	0	0
7280	DRUG PURCHASES	182,420	381,912	39	2	0	0 ***
7281	DRUG PURCHASES-OTHER	199,492		39	2		
7380	LABORATORY SERVICES	14,221	444,977	39	3	0	0
7410	HOME HEALTH SALARY			39	1	0	0
7440	HOME HEALTH SICK & VAC			39	1	0	0
7450	HOME HEALTH EXPENSES			39	3	0	0
7510	ACTIVITES WAGES	96,731	101,638	11	1	0	0
7540	ACTIVITIES SICK & VAC	4,907		11	1	0	0
7590	ACTIVITIES SUPPLIES	7,862	7,862	11	2	0	0
7595	ACTIVITIES FEES	0	0	11	3	0	0
7610	PT WAGES			39	1	0	0
7611	PT SICK & VACATION			39	1	0	0
7620	PT FEES	212,447		39	3	0	0 ***
7660	PT SUPPLIES	0		39	2	0	0
7710	SOCIAL SERVICE WAGES	71,874	75,844	12	1	0	0
7720	SOCIAL SERVICE SICK & V	3,970		12	1	0	0
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0
7740	OT FEE	188,732		39	3	0	0 ***
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0
7770	SPEECH THERAPY FEE	29,577		39	3	0	0 ***
7800	BEAUTICIAN WAGES		0	40	1	0	0
7810	BEAUTICIAN SICK & VAC			40	1	0	0
7820	BEAUTICIAN FEES	5,523	5,523	40	3	0	0
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0
7910	VOLUNTEER COORDINATOR			21	1	0	0
7940	VOL COORD SICK & VAC			21	1	0	0
7960	VOL COORD SUPPLIES	0		21	2	0	0
8100	RENT	200,000	200,000	34	3	0	0

8120	INTEREST EXPENSE	23,244	23,244	32	3	14	-2,633	
8130	DEPRECIATION	206,347	206,347	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-2,633		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	715		0	0	0	0	
		5,541,157	5,544,971					
			3,814					

GRAND TOTALS

-32,459

(NET INCOME)

-117,106

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	9,816	9,816
IPA	15,881	15,881
medicare	3,424	3,424
		29,121
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

.ES

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FUND

ERIA

EBT

EBT

3,007 3,007 PATIENT 9,816

3,007	3,007 PATIENT	15,881
3,007	3,007 PATIENT	3,424
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CI	(5,027,121)
3,020	3,020 BASIC CI	0
3,030	3,030 BASIC CI	0
3,040		0
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(48,702)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(727,688)
3,101		0
3,110	3,110 PHYSICA	(1,487,451)
3,111		0
3,112	3,112 PHYSICA	0
3,113	3,113 PHYSICA	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT TH	0
3,153	3,153 ST/OT TH	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTH	0
3,411	3,411 MEDICAL	0
3,420	3,420 MEDICAL	1,672,786
3,500		

3,520	3,520 RENT IN	0
3,530	3,530 BEAUTY	(8,433)
3,560		(517)
3,570	3,570 VENDINC	(2,055)
3,590	3,590 EQUIPMI	(13,751)
3,595	3,595 RESIDEN	(7,292)
3,600	3,600 MISC INC	0
4,110	4,110 G&A WA	198,699
4,111	4,111 ADMINIS	94,723
4,115	4,115 G&A PTC	14,656
4,120	4,120 EMPLOY	13,994
4,125		0
4,130	4,130 EMPLOY	23,103
4,135	4,135 EMPLOY	(3,314)
4,250	4,250 OFFICE S	13,432
4,255	4,255 POSTAGI	3,350
4,260	4,260 TELEPHC	8,584
4,275	4,275 TRAININ	6,274
4,276		0
4,280	4,280 GENERA	4,513
4,281	4,281 MEAL E	551
4,285	4,285 EDUCAT	2,052
4,289	4,289 MEETINC	0
4,290	4,290 HELP WA	4,254
4,291	4,291 PROMOT	47,335
4,292	4,292 PUBLIC I	17,527
4,300	4,300 LICENSE	51,820
4,310	4,310 DUES & S	6,642
4,320	4,320 CONTRIE	0
4,350	4,350 PROFESS	8,636
4,355	4,355 MEDICAL	9,600
4,362		914
4,363		5,520

4,364	4,364 SOCIAL S	3,500
4,370	4,370 TV RENT	9,406
4,383	4,383 BACKGR	2,625
4,390	4,390 OTHER T	715
4,400	4,400 PAYROL	233,954
4,401	4,401 PAYROL	9,208
4,410	4,410 GROUP I	190,473
4,420	4,420 LIABILIT	42,093
4,430	4,430 WORKM	46,960
4,435	4,435 W/C-FIRS	2,362
4,436	4,436 DRUG TE	2,156
4,450	4,450 MANAGI	245,801
4,460	4,460 BAD DEF	27,000
4,461	4,461 BAD DEF	76,608
4,470	4,470 LOST ITE	1,315
4,475	4,475 UNIFORM	281
4,486	4,486 SERVICE	17,407
4,490	4,490 MISC EX	0
4,496	4,496 MISC. M.	7,846
4,510	4,510 REAL ES	49,214
4,600	4,600 LEASED	2,466
5,110	5,110 MAINTEN	84,192
5,120	5,120 MAINTEN	3,579
5,130	5,130 ELECTRI	39,581
5,131	5,131 NATURA	20,068
5,133	5,133 WATER &	44,668
5,134	5,134 TRASH C	10,945
5,140	5,140 PROP/PL	14,026
5,160	5,160 GENERA	53,177
5,165	5,165 MAINTEN	12,837
5,210	5,210 DIETARY	251,456
5,220	5,220 DIETARY	11,906
5,248	5,248 FOOD PU	254,079

5,250	5,250 SUPPLIE	2,712
5,260	5,260 REPLACI	3,998
5,270	5,270 KITCHEN	7,734
5,295	5,295 MEAL IN	(1,869)
5,310	5,310 LAUNDR	61,072
5,340	5,340 LAUNDR	3,763
5,370	5,370 REPLACI	4,892
5,380		0
5,390	5,390 SUPPLIE	5,711
5,410	5,410 HOUSEK	114,732
5,440	5,440 HOUSEK	5,706
5,480	5,480 SUPPLIE	9,757
5,490	5,490 SUPPLIE	17,736
6,020	6,020 RN WAG	349,701
6,030	6,030 DON WA	61,146
6,035	6,035 ADON W	0
6,040	6,040 RN PTO &	15,652
6,120	6,120 LPN WAG	153,522
6,140	6,140 LPN PTO	6,183
6,220	6,220 AIDES W	717,441
6,240	6,240 AIDES PT	18,556
6,245		
6,246		0
6,247		
6,250		0
6,255		0
6,260		(1,896)
6,270	6,270 REHAB V	120,910
6,275	6,275 REHAB F	7,214
6,290	6,290 NURSINC	107,002
6,295	6,295 NURSINC	53,928
6,390	6,390 REPLACI	15,237
6,490	6,490 OTHER	7,742

7,280	7,280 DRUG PU	182,420
7,281	7,281 DRUG PU	199,492
7,380	7,380 LABORA	7,263
7,391	7,390 X-RAY S	3,228
7,393		3,730
7,510	7,510 ACTIVIT	96,731
7,540	7,540 ACTIVIT	4,907
7,590	7,590 ACTIVIT	7,862
7,620	7,620 PHYSICA	212,447
7,660	7,660 P.T. SUP	0
7,710	7,710 SOCIAL S	71,874
7,720	7,720 SOCIAL S	3,970
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPA	188,732
7,750		0
7,770	7,770 SPEECH '	29,577
7,820	7,820 BEAUTIC	5,523
7,890		0
7,960		0
8,120	8,120 INTERES	880
8,125		22,364
8,130	8,130 DEPRECI	206,347
8,150		0
9,510	9,510 INTERES	(2,633)
9,520	9,520 MISC NO	0
9,530	4,220	0
	8,100	200,000
	9,702	0
	5,230	0
		<u>(32,459)</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 - Minonk, 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