

		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: 0048108

Facility Name: Heritage Health-Mendota

Address: 1201 First Ave Mendota 61342
Number City Zip Code

County: LaSalle

Telephone Number: (815) 539-6745 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

☒ 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-Mendota# 0048108 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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</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>99</u>	TOTALS	<u>99</u>	<u>36,234</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>13,860</u>	<u>6,687</u>	<u>2,870</u>	<u>23,417</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>13,860</u>	<u>6,687</u>	<u>2,870</u>	<u>23,417</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 64.63%

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 2,870Medicare 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	188,768	16,040		204,808		204,808	6,135	210,943		1
2	Food Purchase		175,121		175,121		175,121	45	175,166		2
3	Housekeeping	71,938	28,488		100,426		100,426		100,426		3
4	Laundry	65,249	14,111		79,360		79,360		79,360		4
5	Heat and Other Utilities			69,463	69,463		69,463	1,463	70,926		5
6	Maintenance	62,620	41,351	48,668	152,639		152,639	15,106	167,745		6
7	Other (specify):*										7
8	TOTAL General Services	388,575	275,111	118,131	781,817		781,817	22,749	804,566		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	2,570	10,970		9
10	Nursing and Medical Records	1,584,341	105,665	10,503	1,700,509		1,700,509	1	1,700,510		10
10a	Therapy		264,197	383,203	647,400	(292,636)	354,764	80,528	435,292		10a
11	Activities	60,853	3,543		64,396		64,396		64,396		11
12	Social Services	33,964	11	3,441	37,416		37,416		37,416		12
13	CNA Training		1,140		1,140		1,140	1,024	2,164		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,679,158	374,556	405,547	2,459,261	(292,636)	2,166,625	84,123	2,250,748		16
	C. General Administration										
17	Administrative	83,256			83,256		83,256		83,256		17
18	Directors Fees										18
19	Professional Services			189,345	189,345		189,345	(173,094)	16,251		19
20	Dues, Fees, Subscriptions & Promotions			92,355	92,355	(54,351)	38,004	(21,160)	16,844		20
21	Clerical & General Office Expenses	144,841	20,890	10,997	176,728		176,728	278,697	455,425		21
22	Employee Benefits & Payroll Taxes			484,205	484,205		484,205	39,567	523,772		22
23	Inservice Training & Education			3,095	3,095		3,095	(1,096)	1,999		23
24	Travel and Seminar			2,850	2,850		2,850	(851)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,770	40,770		40,770	10,785	51,555		26
27	Other (specify):*										27
28	TOTAL General Administration	228,097	20,890	823,617	1,072,604	(54,351)	1,018,253	132,848	1,151,101		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,295,830	670,557	1,347,295	4,313,682	(346,987)	3,966,695	239,720	4,206,415		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							155,919	155,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,067	24,067		24,067	78,832	102,899			32
33	Real Estate Taxes							46,369	46,369			33
34	Rent-Facility & Grounds			433,620	433,620		433,620	(428,279)	5,341			34
35	Rent-Equipment & Vehicles			3,437	3,437		3,437	967	4,404			35
36	Other (specify):*											36
37	TOTAL Ownership			461,124	461,124		461,124	(146,192)	314,932			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					292,636	292,636		292,636			39
40	Barber and Beauty Shops		465	7,790	8,255		8,255		8,255			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,351	54,351		54,351			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		465	7,790	8,255	346,987	355,242		355,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,295,830	671,022	1,816,209	4,783,061		4,783,061	93,528	4,876,589			45

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(923)			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	(256)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,096)			16
17	Non-Care Related Fees	(955)			17
18	Fines and Penalties				18
19	Entertainment	(4,562)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,732)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,605)			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)	\$ (39,129)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	132,657		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 132,657		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 93,528		37

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

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

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

Heritage Health-Mendota

Report Period Beginning: ID# 0048108
Ending: 01/01/12
12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(955)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,732)	19	22
23				23
24		0	27	24
25		(27,605)	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	(32,292)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Mendota # 0048108 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	6,135	0	0	0	0	0	0	0	0	6,135	1
2	Food Purchase	0	0	45	0	0	0	0	0	0	0	0	45	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	1,463	0	0	0	0	0	0	0	0	1,463	5
6	Maintenance	0	0	15,106	0	0	0	0	0	0	0	0	15,106	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,749	0	0	0	0	0	0	0	0	22,749	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,570	0	0	0	0	0	0	0	0	2,570	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	80,528	0	0	0	0	0	0	0	0	0	80,528	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	1,024	0	0	0	0	0	0	0	0	1,024	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	80,528	3,595	0	0	0	0	0	0	0	0	84,123	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	(3,732)	(185,613)	16,251	0	0	0	0	0	0	0	0	(173,094)	19
20	Fees, Subscriptions & Promotions	(28,560)	0	7,400	0	0	0	0	0	0	0	0	(21,160)	20
21	Clerical & General Office Expenses	0	0	278,697	0	0	0	0	0	0	0	0	278,697	21
22	Employee Benefits & Payroll Taxes	0	0	39,567	0	0	0	0	0	0	0	0	39,567	22
23	Inservice Training & Education	(1,096)	0	0	0	0	0	0	0	0	0	0	(1,096)	23
24	Travel and Seminar	(4,562)	0	3,711	0	0	0	0	0	0	0	0	(851)	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	10,785	0	0	0	0	0	0	0	0	10,785	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,950)	(185,613)	356,411	0	0	0	0	0	0	0	0	132,848	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(37,950)	(105,085)	382,755	0	0	0	0	0	0	0	0	239,720	29

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 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%	80,528	80,528	2
3	V								3
4	V	19	Adjustment for Related Organization	185,613	Heritage Operations Group, LLC	0.00%		(185,613)	4
5	V								5
6	V	34	Adjustment for Related Organization	433,620	Heritage Manor Real Estate, LLC	0.00%		(433,620)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,327	46,327	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		73,929	73,929	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		139,172	139,172	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,773	4,773	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 619,233			\$ 344,729	\$ * (274,504)	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.		\$	\$ 6,135	15
16	V	2	Food Purchase					45	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,463	19
20	V	6	Maintenance					15,106	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,570	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					1,024	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					16,251	31
32	V	20	Fees, Subscription, Promotions					7,400	32
33	V	21	Clerical & General Office Expenses					278,697	33
34	V	22	Employee Benefits & Payroll Taxes					39,567	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					3,711	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					10,785	38
39	Total			\$			\$ 0	\$ * 382,755	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					16,747	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					386	18
19	V	33	Real Estate Taxes					42	19
20	V	34	Rent-Facility & Grounds					6,264	20
21	V	35	Rent-Equipment & Vehicles					967	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	\$ * 24,406	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
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25								25
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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-Mendota # 0048108 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	99	\$ 6,135	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	99	45	2
3	3	Housekeeping	Beds	2,735	26	0	0	99	0	3
4	4	Laundry	Beds	2,735	26	0	0	99	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	99	1,463	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	99	15,106	6
7	7	Other	Beds	2,735	26	0	0	99	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	99	2,570	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	99	1	9
10	11	Activities	Beds	2,735	26	0	0	99	0	10
11	12	Social Service	Beds	2,735	26	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	99	1,024	12
13	14	Program Transportation	Beds	2,735	26	0	0	99	0	13
14	15	Other	Beds	2,735	26	0	0	99	0	14
15	17	Administrative	Beds	2,735	26	0	0	99	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	99	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	99	16,251	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	99	7,400	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	99	278,697	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	99	39,567	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	99	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	99	3,711	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	99	10,785	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 382,755	25

Facility Name & ID Number Heritage Health-Mendota # 0048108 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	\$		99	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		99	16,747	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			99		3
4	32	Interest	Beds	2,735	26	10,650		99	386	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		99	42	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		99	6,264	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		99	967	7
8	36	Other	Beds	2,735	26			99		8
9	38	Medically Nec Transportation	Beds	2,735	26			99		9
10	39	Ancillary Service Centers	Beds	2,735	26			99		10
11	40	Barber and Beauty Shops	Beds	2,735	26			99		11
12	41	Coffee and Gift Shops	Beds	2,735	26			99		12
13	42	Other	Beds	2,735	26			99		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	\$		\$ 24,406	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			\$	1,375,836			\$	73,929	1						
2	Bank of America		x	Loan Fee Amort								4,773	2						
3													3						
4													4						
5													5						
	Working Capital																		
6	Bank of America		xx	Working Capital								24,067	6						
7													7						
8													8						
9	TOTAL Facility Related						\$	1,375,836				\$	102,769	9					
	B. Non-Facility Related*																		
10	Interest Income											(256)	10						
11													11						
12	Allocated Corporate											386	12						
13													13						
14	TOTAL Non-Facility Related						\$					\$	130	14					
15	TOTALS (line 9+line14)						\$	1,375,836				\$	102,899	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	46,327	2
3. Under or (over) accrual (line 2 minus line 1).	\$	46,327	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.	\$	46,327	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2007	8
		9
		10
		11
	46,327	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Heritage Health-Mendota

COUNTY
LaSalle

FACILITY IDPH LICENSE NUMBER
0048108

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.	0134100020		\$ 46,327.00	\$ 46,327.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 46,327.00	\$ 46,327.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,055 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>26,150</u>	1
2					2
3	TOTALS			\$ <u>26,150</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	99				\$ 697,500	\$		\$	\$	4
5					408,657					5
6										6
7										7
8										8
	Improvement Type**									
9	1980 Improvements		1980		8,150					9
10	1981 Improvements		1981		20,492					10
11	1982 Improvements		1982		9,185					11
12	1983 Improvements		1983		5,682					12
13	1984 Improvements		1984		11,488					13
14	1985 Improvements		1985		7,710					14
15	1986 Improvements		1986		2,255					15
16	1987 Improvements		1987		9,037					16
17	1988 Improvements		1988		21,297					17
18	1989 Improvements		1989		4,653					18
19	1990 Improvements		1990		36,595					19
20	1991 Improvements		1991							20
21	1992 Improvements		1992		10,646					21
22	1993 Improvements		1993		62,261					22
23	1994 Improvements		1994		10,869					23
24	1995 Improvements		1995		18,523					24
25	Exterior Door		1996		2,563					25
26	Shower Tile		1996		806					26
27	Kitchen Heat/Cool Unit		1996		14,062					27
28	Resident Room Painting		1996		2,067					28
29										29
30										30
31										31
32										32
33	C/O Allocation					16,747			(16,747)	33
34	Book Depreciation					103,594		103,594		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	Garbage Disposal	1997	\$ 2,030	\$		\$	\$	\$	37
38	Generator	1997	39,380						38
39	Parking Lot Asphalt	1997	2,210						39
40	Shower	1997	701						40
41									41
42	Kitchen Drain	1998	3,245						42
43	Walk in Cooler Repair	1998	2,215						43
44	A/C Unit	1998	1,615						44
45	Landscaping	1998	4,696						45
46									46
47	Door Alarm System	1999	11,750						47
48	Air Conditioning Condensing Unit	1999	1,027						48
49	Water Softener	1999	4,493						49
50									50
51	Air conditioner (3)	2000	2,221						51
52	Sprinklers	2000	1,864						52
53	Resident Room Doors (45)	2000	1,724						53
54	Facility Remodel -- Materials	2000	410,365						54
55	Facility Remodel -- Labor	2000	4,030						55
56	Facility Remodel -- Professional Fees	2000	23,932						56
57	Facility Remodel -- Interior Design	2000	36,998						57
58	Water Softener	2000	4,713						58
59									59
60	Parking Spaces	2001	1,452						60
61	Water Heater	2001	2,847						61
62									62
63	Water Heater	2002	3,816						63
64	Wood door	2002	677						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,932,499	\$ 120,341		\$ 103,594	\$ (16,747)	\$	70

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

Facility Name & ID Number Heritage Health-Mendota

0048108

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,932,499	\$ 120,341		\$ 103,594	\$ (16,747)		1
2	Furnace	2003	2,491						2
3	A/C Unit	2003	3,083						3
4	Condensing Unit	2003	1,353						4
5									5
6	Heat/Cool Unit	2004	2,498						6
7	Disposal	2004	989						7
8	Garage Repairs	2004	4,866						8
9	Compressor	2004	1,805						9
10	Emergency Outlets	2004	1,565						10
11	Furnace	2004	6,280						11
12									12
13	Exterior Door	2005	3,161						13
14	Holding Tank	2005	3,897						14
15	Smoke Detector	2005	1,919						15
16	A/C Unit	2005	4,248						16
17	Parking Lot	2005	68,313						17
18	Dumpster Pad	2005	1,547						18
19	Sidewalks	2005	7,850						19
20									20
21	Floor -- entry way	2006	19,178						21
22	Shower rehab	2006	6,246						22
23	Phone system	2006	1,836						23
24	A/C Unit	2006	2,201						24
25	Compressor	2006	1,642						25
26	Remodel TLC unit -- paint, wallpaper	2006	6,126						26
27	Parking Lot	2006	3,633						27
28	Roof	2006	148,938						28
29	Valance	2006	581						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,238,745	\$ 120,341		\$ 103,594	\$ (16,747)		34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,238,745	\$ 120,341		\$ 103,594	\$ (16,747)		1
2									2
3	Metal Roof	2007	49,988						3
4	Door Alarm	2007	2,986						4
5	HVAC	2007	3,370						5
6	Sprinkler system	2007	101,380						6
7	Wander Alarm	2007	8,092						7
8	fire Alarm	2007	42,223						8
9	Water Heater	2007	3,820						9
10	Grab Bars	2007	4,193						10
11									11
12	Heat/Cool Units	2008	2,713						12
13									13
14	Water Heater	2009	6,340						14
15	Sidewalks	2009	35,988						15
16	Furnace	2009	4,190						16
17									17
18	Shower Room Tile	2010	20,608						18
19	Landscaping	2010	6,702						19
20									20
21									21
22	Furnace	2011	3,513						22
23									23
24	Physical Therapy Room -- Replace Flooring	2012	7,887						24
25	Lighting Upgrade	2012	3,269						25
26	Cpmpressor	2012	3,588						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,549,595	\$ 120,341		\$ 103,594	\$ (16,747)		34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,549,595	\$ 120,341		\$ 103,594	\$ (16,747)		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)		\$ 2,549,595	\$ 120,341		\$ 103,594	\$ (16,747)		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	\$925,197	\$35,578	\$35,578	\$		\$	71
72	Current Year Purchases	26,046						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$951,243	\$35,578	\$35,578	\$		\$	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)	\$3,526,988	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$155,919	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$139,172	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(16,747)	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: \$ 3,437
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 153,651	\$		\$ 153,651	1
2	Licensed Speech and Language Development Therapist		hrs			14,165			14,165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			186,773	175		186,948	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				264,022		264,022	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					28,614			28,614	13
14	TOTAL			\$		\$ 383,203	\$ 264,197		\$ 647,400	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	\$ 392	\$	1
2	Cash-Patient Deposits	11,091		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	776,784		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,142		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,290,193)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (468,784)	\$	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)	\$ (468,784)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 147,859	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,091		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,922		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,653		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>	91,614		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 491,139	\$	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)	\$ 491,139	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (959,923)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (468,784)	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (430,813)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (430,813)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(529,110)	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)	\$ (529,110)	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)	\$ (959,923)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health-Mendota# 0048108Report Period Beginning: 01/01/12Ending: 12/31/12

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

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

		1	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,901,109	1
2	Discounts and Allowances for all Levels	(1,521,100)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,380,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,377,402	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,377,402	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	2,102	12
13	Barber and Beauty Care	10,959	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	923	16
17	Sale of Drugs	482,338	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(38)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 496,284	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	256	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 256	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)	\$ 4,253,951	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	781,817	31
32	Health Care	2,459,261	32
33	General Administration	1,072,604	33
	B. Capital Expense		
34	Ownership	461,124	34
	C. Ancillary Expense		
35	Special Cost Centers	8,255	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,783,061	40
41	Income before Income Taxes (line 30 minus line 40)**	(529,110)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (529,110)	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	1,788	2,032	\$ 64,560	\$ 31.77	1
2	Assistant Director of Nursing	1,784	2,024	59,474	29.38	2
3	Registered Nurses	9,976	10,556	310,302	29.40	3
4	Licensed Practical Nurses	13,437	14,963	322,361	21.54	4
5	CNAs & Orderlies	60,385	64,823	808,128	12.47	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	970	1,199	19,516	16.28	8
9	Activity Director					9
10	Activity Assistants	4,852	5,128	60,853	11.87	10
11	Social Service Workers	1,752	1,956	33,964	17.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,069	17,111	188,768	11.03	15
16	Dishwashers					16
17	Maintenance Workers	3,603	3,987	62,620	15.71	17
18	Housekeepers	6,600	7,113	71,938	10.11	18
19	Laundry	5,025	5,871	65,249	11.11	19
20	Administrator	1,950	2,080	83,256	40.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,232	7,099	144,841	20.40	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)	134,423	145,942	\$ 2,295,830 *	\$ 15.73	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		8,400		36
37	Medical Records Consultant		492		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,940		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		3,441		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,273		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	94	3,292		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	94	\$ 3,292		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Catherine McDowell			\$ 83,256
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,256
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		\$ 185,613
			0
			0
Legal adj to Zero			3,732
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 189,345
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 46,586
Unemployment Compensation Insurance			47,500
FICA Taxes			175,631
Employee Health Insurance			200,271
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			0
Other Benefits			14,217
Central Office Allocation			39,567
TOTAL (agree to Schedule V, line 22, col.8)			\$ 523,772
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			1,491
Health Care Worker Background Check (Indicate # of checks performed)			1,260
Patient Background Checks			
			7,530
Dues & Subscriptions			6,596
License & Fees			1,052
Central Office Allocation			7,400
Less: Public Relations Expense			(7,530)
Non-allowable advertising			(955)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 16,844
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
			2,542
			36
Seminar Expense			272
			(851)
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,999

*** 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. \$ 54,351
 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. \$ 1,494

(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	392				1,009		1,009	PETTY CASH
1010	CASH IN BANK					1,100		1,100	ACCTS RECEIV-PRIVATE
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBLES
1100	ACCOUNTS RECEIVABLE	776,784				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 INSURANCE
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	33,142				1,310		1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY
1300	FOOD INVENTORY					1,409		1,409	LAND
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITURE & EQUIPMENT
1409	LAND	0				1,460			
1450	FURNITURE & EQUIPMENT	0				1,475		1,475	CODE ALERT MONITOR SYSTEM
1460	ACCUM DEPR-FURN & EQU	0				1,490		1,490	ACCUM DEPR-BUILDING
1475	BUILDING & IMPROVEMEN	0				1,530		1,530	RESIDENT FUNDS
1490	ACCUM DEPR-BUILDING	0				1,550		1,550	LOAN FEES
1530	RESIDENT FUNDS	11,091				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	0				1,850		1,850	INTERCOMPANY
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUNTS PAYABLE
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	-1,290,193				2,100		2,100	ACCRUED PAYROLL
2010	ACCOUNTS PAYABLE	-147,859				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-98,574				2,110		2,110	ACCRUED PTO PAY
2110	ACCRUED VACATION PAY	-138,348				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAXES PAYABLE
2125	FICA TAX PAYABLE	-3,653	-3,653	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 REFUND
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 ACCRUED INTEREST PAYABLE
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYMENTS PAYABLE
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ESTATE TAXES PAYABLE
2310	SALES TAX PAYABLE			2,385	
2320	IPA PAYMENTS PAYABLE	-91,614		2,400	2,400 CURRENT PORTION OF LT DEBT
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO RESIDENTS
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE BANK #1
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
2460	INCOME TAXES PAYABLE				net income
2512	DUE TO RESIDENTS	-11,091			
2600	MORTGAGE PAYABLE	0			
2650	EQUIPMENT LOAN PAYABLE				balance
2695	CURRENT PORTION LT DEBT				
2696	DEFERRED INCOME TAXES				
2710	COMMON STOCK				
2720	RETAINED EARNINGS	430,813			
2970	PROFIT/LOSS FOR PERIOD	529,110			
3007.1	PATIENT DAYS-PRIVATE	6,687			

3007.2	PATIENT DAYS-IPA	13,860				
3007.3	PATIENT DAYS-MEDICARE	2,870				
3007.4	PATIENT DAYS-CONVERSION					
3007.5	PATIENT DAYS-LICENSED					
3007.6	PATIENT DAYS-TOTAL					
3010	1 BASIC CHARGE-PRIVATE &	-3,848,124	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	-43,642	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	-482,338	0	0	0	0
3101	17 DRUGS-OTHER					
3110	6 PT-PRIVATE	-1,377,402	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	1,521,100	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	-923		6	0	6	-923	
3530	13 BEAUTY SHOP	-10,959		0	0	0	0	
3560	12 ACTIVITY FUND INCOME	-2,430		0	0	0	0	
3570	12 VENDING INCOME/EXPENSE	328		0	0	0	0	
3580	12 MANAGEMENT FEES			0	0	0	0	
3590	1 EQUIPMENT RENTAL	-9,343		0	0	0	0	
3595	21 RESIDENT TRANSPORTATION	38		0	0	0	0	
3600	21 MISC INCOME	0		0	0	0	0	
4110	GENERAL & ADMINISTRATIVE WAGES	134,373	144,841	21	1	17	0	
4111	ADMINISTRATOR WAGES	83,256	83,256	17	1	0	0	
4115	VACATION & SICK - G&A	10,468		21	1	0	0	
4120 4475	EMPLOYEE BENEFITS	10,142	484,205	22	3	0	0	
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	
4130	EMPLOYEE SCHOLORSHIP	3,357		21	1	0	0	
4135	EMPLOYEE SCHOLORSHIP	718		23	3	0	0	
4220	DIRECTORS FEES	0	0	18	3	0	0	
4250 4255	OFFICE SUPPLIES	20,890	20,890	21	2	0	0	
4260	TELEPHONE	10,997	10,997	21	3	0	0	
4275	TRAINING & EMPLOYEE DEVELOPMENT	3,095	3,095	23	3	16	-1,096 **	
4280	GENERAL TRAVEL	2,542	2,850	24	3	16	0	
4281	MEAL EXPENSE FOR TRAVEL	36		24	3	19	0	
4285	EDUCATION & SEMINAR	272		24	3	19	-4,562 ***	
4290	HELP WANTED ADVERTISING	1,491	92,355	20	3	0	0	-54,351
4291	PROMOTIONAL ADVERTISING	20,075		20	3	25	-20,075	
4292	PUBLIC RELATIONS	7,530		20	3	25	-7,530	
4300	LICENSES & FEES	55,403		20	3	17	0	
4310	DUES & SUBSCRIPTIONS	6,596		20	3	17	-955	
4320	CONTRIBUTIONS	0		27	3	20	0	
4350	PROFESSIONAL FEES	3,732	189,345	19	3	22	-3,732	
4355	MEDICAL DIRECTOR	8,400	8,400	9	3	0	0	
4360	UTILIZATION REVIEW	0		10	3	0	0	
4361	OTHER PHYSICIAN FEES			39	3	0	0	

4362	MEDICAL RECORDS CONSULT	492		10	3	0	0
4363	PHARMACIST FEES	5,940		10	3	0	0
4364	SOC SERV/ACT CONSULT	3,441	3,441	12	3	0	0
4370	TV RENTAL	2,873		35	3	5	0
4380	INCOME TAXES		0	27	3	26	0
4383	BACKGROUND CHECKS	1,260		20	3	26	0
4400	PAYROLL TAXES	214,691		22	3	0	0
4401	PAYROLL TAXES ADMINIS	8,440		22	3	0	0
4410	GROUP INSURANCE	200,271		22	3	0	0
4420	LIABILITY INSURANCE	40,770	40,770	26	3	0	0
4425	INSURANCE-OWNERS			22	3	21	0
4430	WORKMENS COMP INSUR/	46,586		22	3	0	0
4450	CENTRAL OFFICE FEES	185,613		19	3	34	0 **
4460	BAD DEBTS	0		27	3	24	0
4470	LOST ITEMS-RESIDENTS	0		27	3	0	
4490	MISCELLANEOUS	0		27	3	0	0
4510	REAL ESTATE TAXES	0	0	33	3	0	0
4600	LEASED EQUIPMENT	564	3,437	35	3	16	0
5110	MAINTENANCE SALARIES	58,077	62,620	6	1	0	0
5120	MAINTENANCE SICK & VA	4,543		6	1	0	0
5130	ELECTRIC	36,000	69,463	5	3	0	0
5131	NATURAL GAS	10,279		5	3	0	0
5132	HEATING & DEISEL OIL			5	3	0	0
5133	WATER & SEWER	23,184		5	3	0	0
5134	TRASH COLLECTION	11,154	48,668	6	3	0	0
5140	PROPERTY PLANT REPLAC	2,329	41,351	6	2	0	0
5160	GENERAL REPAIR & MAIN	39,022		6	2	0	0
5165	MAINTENANCE CONTRAC	37,514		6	3	0	0
5210	DIETARY WAGES	181,216	188,768	1	1	0	0
5220	DIETARY SICK & VAC	7,552		1	1	0	0
5240	SALES TAX			2	3	13	0
5248	FOOD PURCHASES	176,615	175,121	2	2	0	0
5250	SUPPLIES-DISHWASHING	3,790	16,040	1	2	0	0

5260	DIETARY REPLACEMENT	2,101		1	2	0	0
5270	KITCHEN SUPPLIES-PAPER	10,149		1	2	0	0
5295	MEAL CREDIT	-1,494		2	2	0	0
5310	LAUNDRY WAGES	59,979	65,249	4	1	0	0
5340	LAUNDRY SICK & VAC	5,270		4	1	0	0
5370	LAUNDRY REPLACEMENT	9,147	14,111	4	2	0	0
5380	LAUNDRY REIMBURSEMENT			4	3	0	0
5390	LAUNDRY SUPPLIES	4,964		4	2	0	0
5410	HOUSEKEEPING WAGES	68,419	71,938	3	1	0	0
5440	HOUSEKEEPING SICK & VAC	3,519		3	1	0	0
5480	HOUSEKEEPING SUPPLIES	10,254	28,488	3	2	0	0
5490	HOUSEKEEPING SUPPLIES-	18,234		3	2	0	0
6010	RN WAGES-MEDICARE		1,584,341	10	1	0	0
6020	RN WAGES-NON MEDICAR	292,418		10	1	0	0
6030	DON WAGES	64,560		10	1	0	0
6035	ADON	59,474		10	1	0	0
6040	RN SICK & VACATION	17,884		10	1	0	0
6110	LPN WAGES-MEDICARE	309,943		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	12,418		10	1	0	0
6210	AIDE WAGES-MEDICARE			10	1	0	0
6220	AIDE WAGES-NON MEDICAL	776,298		10	1	0	0
6230	WARD CLERKS			10	1	0	0
6240	AIDE VACATION & SICK	31,830		10	1	0	0
6245	CONTRACT NURSES-RN	0		10	3	0	0
6246	CONTRACT NURSES-LPN	3,292		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	1,140	1,140	13	2	0	0
6260	NURSE AIDE TRAINING RE	0		0	0	0	0
6270	REHAB WAGES	17,399		10	1	0	0
6275	REHAB SICK & VAC	2,117		10	1	0	0

6280	NURSING DEPT EDUCATION			23	3	0	0
6290	NURSING SUPPLIES	87,864	105,665	10	2	0	0
6295	NURSING SUPPLIES	11,828		10	2	0	0
6390	REPLACEMENT-NURSING	5,973		10	2	0	0
6490	NURSING OTHER	779	10,503	10	3	0	0
7280	DRUG PURCHASES	129,264	264,197	39	2	0	0 ***
7281	DRUG PURCHASES-OTHER	134,758		39	2		
7380	LABORATORY SERVICES	28,614	383,203	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	58,349	60,853	11	1	0	0
7540	ACTIVITIES SICK & VAC	2,504		11	1	0	0
7590	ACTIVITIES SUPPLIES	3,543	3,543	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	186,773		39	3	0	0 ***
7660	PT SUPPLIES	175		39	2	0	0
7710	SOCIAL SERVICE WAGES	30,399	33,964	12	1	0	0
7720	SOCIAL SERVICE SICK & V	3,565		12	1	0	0
7730	SOCIAL SERVICE EXPENSE	11	11	12	2	0	0
7740	OT FEE	153,651		39	3	0	0 ***
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0
7770	SPEECH THERAPY FEE	14,165		39	3	0	0 ***
7800	BEAUTICIAN WAGES		0	40	1	0	0
7810	BEAUTICIAN SICK & VAC			40	1	0	0
7820	BEAUTICIAN FEES	7,790	7,790	40	3	0	0
7890	BEAUTY SHOP SUPPLIES	465	465	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	433,620	433,620	34	3	0	0

8120	INTEREST EXPENSE	24,067	24,067	32	3	14	-256	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-256		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		4,782,805	4,783,061					
			256					

GRAND TOTALS

529,110

-39,129

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	6,687	6,687
IPA	13,860	13,860
medicare	2,870	2,870
		23,417
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

392
776,784

33,142

0
0
0
0
0
11,091
0

(1,290,193)
(147,859)

(98,574)

(138,348)

(3,653)

0

(91,614)

0

0

(11,091)

0

430,813

529,110

0

3,007

3,007 PATIENT DAYS-P

6,687

3,007	3,007 PATIENT DAYS-II	13,860
3,007	3,007 PATIENT DAYS-M	2,870
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CHARGE-F	(3,848,124)
3,020	3,020 BASIC CHARGE-I	0
3,030	3,030 BASIC CHARGE-M	0
3,040		0
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING SUPPL-	(43,642)
3,081	3,081 NURSING SUPPLI	0
3,082	3,082 NURSING SUPPLI	0
3,083	3,083 NURSING SUPPLI	0
3,100	3,100 DRUGS-MEDICAF	(482,338)
3,101		0
3,110	3,110 PHYSICAL THERA	(1,377,402)
3,111		0
3,112	3,112 PHYSICAL THERA	0
3,113	3,113 PHYSICAL THERA	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT THERAPY-	0
3,153	3,153 ST/OT THERAPY-	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHER DISCO	0
3,411	3,411 MEDICARE PT B-I	0
3,420	3,420 MEDICARE DISCO	1,445,655
3,500		

3,520	3,520 RENT INCOME	(923)
3,530	3,530 BEAUTY SHOP	(10,959)
3,560		(2,430)
3,570	3,570 VENDING INCOM	328
3,590	3,590 EQUIPMENT REN	(9,343)
3,595	3,595 RESIDENT TRANS	38
3,600	3,600 MISC INCOME	0
4,110	4,110 G&A WAGES	134,373
4,111	4,111 ADMINISTRATOR	83,256
4,115	4,115 G&A PTO & RESE	10,468
4,120	4,120 EMPLOYEE BENE	10,349
4,125		0
4,130	4,130 EMPLOYEE SCHC	3,357
4,135	4,135 EMPLOYEE SCHC	718
4,250	4,250 OFFICE SUPPLIES	4,583
4,255	4,255 POSTAGE	1,992
4,260	4,260 TELEPHONE	10,997
4,275	4,275 TRAINING & EMP	3,095
4,276		79
4,280	4,280 GENERAL TRAVE	2,542
4,281	4,281 MEAL EXPENSE I	36
4,285	4,285 EDUCATION/SEM	199
4,289	4,289 MEETINGS EXPEI	73
4,290	4,290 HELP WANTED A	1,491
4,291	4,291 PROMOTIONAL A	20,075
4,292	4,292 PUBLIC RELATIO	7,530
4,300	4,300 LICENSE & FEES	55,403
4,310	4,310 DUES & SUBSCRI	6,596
4,320	4,320 CONTRIBUTIONS	0
4,350	4,350 PROFESSIONAL F	3,732
4,355	4,355 MEDICAL DIREC	8,400
4,362		492
4,363		5,940

4,364	4,364 SOCIAL SERV/AC	3,441
4,370	4,370 TV RENTAL	2,873
4,383	4,383 BACKGROUND C	1,260
4,390	4,390 OTHER TAXES	0
4,400	4,400 PAYROLL TAXES	214,691
4,401	4,401 PAYROLL TAXES	8,440
4,410	4,410 GROUP INSURAN	200,271
4,420	4,420 LIABILITY INSUR	40,770
4,430	4,430 WORKMAN'S COI	45,590
4,435	4,435 W/C-FIRST AID C	0
4,436	4,436 DRUG TESTING M	917
4,450	4,450 MANAGEMENT F	185,613
4,460	4,460 BAD DEBTS	0
4,461	4,461 BAD DEBTS	75,445
4,470	4,470 LOST ITEMS-RES	0
4,475	4,475 UNIFORM EXP/PE	(207)
4,486	4,486 SERVICE CONTRA	16,916
4,490	4,490 MISC EXPENSE	185
4,496	4,496 MISC. M.I.S. EXPE	14,315
4,510	4,510 REAL ESTATE TA	0
4,600	4,600 LEASED EQUIPM	564
5,110	5,110 MAINTENANCE V	58,077
5,120	5,120 MAINTENANCE P	4,543
5,130	5,130 ELECTRIC	36,000
5,131	5,131 NATURAL GAS	10,279
5,133	5,133 WATER & SEWER	23,184
5,134	5,134 TRASH COLLECT	11,154
5,140	5,140 PROP/PLANT REP	2,329
5,160	5,160 GENERAL REPAIR	39,022
5,165	5,165 MAINTENANCE C	20,598
5,210	5,210 DIETARY WAGES	181,216
5,220	5,220 DIETARY PTO & I	7,552
5,248	5,248 FOOD PURCHASE	176,430

5,250	5,250 SUPPLIES DISHW	3,790
5,260	5,260 REPLACEMENT-I	2,101
5,270	5,270 KITCHEN SUPPLI	10,149
5,295	5,295 MEAL INCOME	(1,494)
5,310	5,310 LAUNDRY WAGE	59,979
5,340	5,340 LAUNDRY PTO &	5,270
5,370	5,370 REPLACEMENT-I	9,147
5,380		0
5,390	5,390 SUPPLIES	4,964
5,410	5,410 HOUSEKEEPING '	68,419
5,440	5,440 HOUSEKEEPING I	3,519
5,480	5,480 SUPPLIES-CLEAN	10,254
5,490	5,490 SUPPLIES-HOUSE	18,234
6,020	6,020 RN WAGES	292,418
6,030	6,030 DON WAGES	64,560
6,035	6,035 ADON WAGES	59,474
6,040	6,040 RN PTO & RESER'	17,884
6,120	6,120 LPN WAGES	309,943
6,140	6,140 LPN PTO & RESEI	12,418
6,220	6,220 AIDES WAGES	776,298
6,240	6,240 AIDES PTO & RES	31,830
6,245		
6,246		3,292
6,247		
6,250		0
6,255		1,140
6,260		0
6,270	6,270 REHAB WAGES	17,399
6,275	6,275 REHAB PTO & RE	2,117
6,290	6,290 NURSING SUPPLI	87,864
6,295	6,295 NURSING SUPPLI	11,828
6,390	6,390 REPLACEMENT-N	5,973
6,490	6,490 OTHER	779

7,280	7,280 DRUG PURCHASE	129,264
7,281	7,281 DRUG PURCHASE	134,758
7,380	7,380 LABORATORY SE	14,981
7,391	7,390 X-RAY SERVICES	3,052
7,393		10,581
7,510	7,510 ACTIVITIES WAG	58,349
7,540	7,540 ACTIVITIES PTO	2,504
7,590	7,590 ACTIVITIES SUPP	3,543
7,620	7,620 PHYSICAL THERA	186,773
7,660	7,660 P.T. SUPPLY - BIL	175
7,710	7,710 SOCIAL SERVICE	30,399
7,720	7,720 SOCIAL SERVICE	3,565
7,730	7,730 SOCIAL SERVICE	11
7,740	7,740 OCCUPATIONAL	153,651
7,750		0
7,770	7,770 SPEECH THERAPY	14,165
7,820	7,820 BEAUTICIAN FEE	7,790
7,890		465
7,960		0
8,120	8,120 INTEREST	0
8,125		24,067
8,130	8,130 DEPRECIATION	0
8,150		0
9,510	9,510 INTEREST INCOM	(256)
9,520	9,520 MISC NON-OPERA	0
9,530	4,220	0
	8,100	433,620
	9,702	0
	5,230	0
		<u>529,110</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 Living Center, IL	37-0967671001	19976