

		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: <u>0048074</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heritage Health Mt Zion</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.																							
Address: <u>1225 Woodland Dr</u> <u>Mt Zion</u> <u>62549</u>																									
Number City Zip Code																									
County: <u>Macon</u>																									
Telephone Number: <u>(217) 864-2356</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Craig Ater</u></td></tr><tr><td>(Title) <u>Exec VP & CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) _____ Fax # () _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Craig Ater</u>	(Title) <u>Exec VP & CFO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) _____ Fax # () _____												
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	(Type or Print Name) <u>Craig Ater</u>																								
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	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) _____ Fax # () _____																								
Date of Initial License for Current Owners: <u>07/2007</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: _____																									

Facility Name & ID Number Heritage Health Mt Zion# 0048074 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>73</u>	Skilled (SNF)	<u>73</u>	<u>26,718</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>73</u>	TOTALS	<u>73</u>	<u>26,718</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>17,473</u>	<u>3,491</u>	<u>4,344</u>	<u>25,308</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>17,473</u>	<u>3,491</u>	<u>4,344</u>	<u>25,308</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.72%

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 4,344Medicare 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						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	191,121	9,157		200,278		200,278	4,524	204,802		1
2	Food Purchase		206,005		206,005		206,005	33	206,038		2
3	Housekeeping	70,759	20,720		91,479		91,479		91,479		3
4	Laundry	90,271	7,936		98,207		98,207		98,207		4
5	Heat and Other Utilities			91,171	91,171		91,171	1,079	92,250		5
6	Maintenance	39,269	52,335	37,897	129,501		129,501	11,139	140,640		6
7	Other (specify):*										7
8	TOTAL General Services	391,420	296,153	129,068	816,641		816,641	16,775	833,416		8
	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600	1,895	23,495		9
10	Nursing and Medical Records	1,265,275	125,170	7,813	1,398,258		1,398,258	1	1,398,259		10
10a	Therapy		310,411	583,892	894,303	(327,703)	566,600	33,750	600,350		10a
11	Activities	47,350	4,031		51,381		51,381		51,381		11
12	Social Services	48,151		6,338	54,489		54,489		54,489		12
13	CNA Training		608		608		608	755	1,363		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,360,776	440,220	619,643	2,420,639	(327,703)	2,092,936	36,401	2,129,337		16
	C. General Administration										
17	Administrative	84,121			84,121		84,121		84,121		17
18	Directors Fees										18
19	Professional Services			211,090	211,090		211,090	(199,107)	11,983		19
20	Dues, Fees, Subscriptions & Promotions			95,598	95,598	(40,077)	55,521	(32,416)	23,105		20
21	Clerical & General Office Expenses	135,068	17,529	5,791	158,388		158,388	205,504	363,892		21
22	Employee Benefits & Payroll Taxes			387,874	387,874		387,874	29,176	417,050		22
23	Inservice Training & Education			3,319	3,319		3,319	(1,320)	1,999		23
24	Travel and Seminar			7,676	7,676		7,676	(5,677)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,638	39,638		39,638	7,953	47,591		26
27	Other (specify):*			972	972		972	(47)	925		27
28	TOTAL General Administration	219,189	17,529	751,958	988,676	(40,077)	948,599	4,066	952,665		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,971,385	753,902	1,500,669	4,225,956	(367,780)	3,858,176	57,242	3,915,418		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							225,204	225,204			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,221	18,221		18,221	101,760	119,981			32
33	Real Estate Taxes							60,259	60,259			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,881)	4,619			34
35	Rent-Equipment & Vehicles			6,115	6,115		6,115	713	6,828			35
36	Other (specify):*											36
37	TOTAL Ownership			352,836	352,836		352,836	64,055	416,891			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					327,703	327,703		327,703			39
40	Barber and Beauty Shops			15,540	15,540		15,540		15,540			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					40,077	40,077		40,077			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			15,540	15,540	367,780	383,320		383,320			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,971,385	753,902	1,869,045	4,594,332		4,594,332	121,297	4,715,629			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				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	(3,354)			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)	(1,320)			16
17	Non-Care Related Fees	(785)			17
18	Fines and Penalties				18
19	Entertainment	(8,414)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,451)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47)			24
25	Fund Raising, Advertising and Promotional	(37,087)			25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,458)		\$	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)	179,755		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 179,755		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 121,297		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 Mt Zion

Report Period Beginning: ID# 0048074
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		(785)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(7,451)	19	22
23				23
24		(47)	27	24
25		(37,087)	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	(45,370)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mt Zion # 0048074 Report Period Beginning: 01/01/12 Ending: 12/31/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,524	0	0	0	0	0	0	0	0	4,524	1
2	Food Purchase	0	0	33	0	0	0	0	0	0	0	0	33	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	1,079	0	0	0	0	0	0	0	0	1,079	5
6	Maintenance	0	0	11,139	0	0	0	0	0	0	0	0	11,139	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	16,775	0	0	0	0	0	0	0	0	16,775	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,895	0	0	0	0	0	0	0	0	1,895	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	33,750	0	0	0	0	0	0	0	0	0	33,750	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	755	0	0	0	0	0	0	0	0	755	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	33,750	2,651	0	0	0	0	0	0	0	0	36,401	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	(7,451)	(203,639)	11,983	0	0	0	0	0	0	0	0	(199,107)	19
20	Fees, Subscriptions & Promotions	(37,872)	0	5,456	0	0	0	0	0	0	0	0	(32,416)	20
21	Clerical & General Office Expenses	0	0	205,504	0	0	0	0	0	0	0	0	205,504	21
22	Employee Benefits & Payroll Taxes	0	0	29,176	0	0	0	0	0	0	0	0	29,176	22
23	Inservice Training & Education	(1,320)	0	0	0	0	0	0	0	0	0	0	(1,320)	23
24	Travel and Seminar	(8,414)	0	2,737	0	0	0	0	0	0	0	0	(5,677)	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	7,953	0	0	0	0	0	0	0	0	7,953	26
27	Other (specify):*	(47)	0	0	0	0	0	0	0	0	0	0	(47)	27
28	TOTAL General Administration	(55,104)	(203,639)	262,809	0	0	0	0	0	0	0	0	4,066	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(55,104)	(169,889)	282,235	0	0	0	0	0	0	0	0	57,242	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%	33,750	33,750	2
3	V								3
4	V	19	Adjustment for Related Organization	203,639	Heritage Operations Group, LLC	0.00%		(203,639)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC	0.00%		(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		60,228	60,228	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		100,057	100,057	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		212,855	212,855	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			\$ 532,139			\$ 411,663	\$ * (120,476)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.		\$	4,524	15
16	V	2	Food Purchase					33	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,079	19
20	V	6	Maintenance					11,139	20
21	V	7	Other					0	21
22	V	9	Medical Director					1,895	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					755	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					11,983	31
32	V	20	Fees, Subscription, Promotions					5,456	32
33	V	21	Clerical & General Office Expenses					205,504	33
34	V	22	Employee Benefits & Payroll Taxes					29,176	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					2,737	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					7,953	38
39	Total			\$			\$ 0	\$ * 282,235	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					12,349	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					284	18
19	V	33	Real Estate Taxes					31	19
20	V	34	Rent-Facility & Grounds					4,619	20
21	V	35	Rent-Equipment & Vehicles					713	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	\$ * 17,996	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 Mt Zion# 0048074

Report Period Beginning:

01/01/12Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,735	26	\$ 169,500	\$ 168,827	73	\$ 4,524	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	73	33	2
3	3	Housekeeping	Beds	2,735	26	0	0	73	0	3
4	4	Laundry	Beds	2,735	26	0	0	73	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	73	1,079	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	73	11,139	6
7	7	Other	Beds	2,735	26	0	0	73	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	73	1,895	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	73	1	9
10	11	Activities	Beds	2,735	26	0	0	73	0	10
11	12	Social Service	Beds	2,735	26	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	73	755	12
13	14	Program Transportation	Beds	2,735	26	0	0	73	0	13
14	15	Other	Beds	2,735	26	0	0	73	0	14
15	17	Administrative	Beds	2,735	26	0	0	73	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	73	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	73	11,983	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	73	5,456	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	73	205,504	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	73	29,176	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	73	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	73	2,737	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	73	7,953	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 282,235	25

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	\$		73	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		73	12,349	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			73		3
4	32	Interest	Beds	2,735	26	10,650		73	284	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		73	31	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		73	4,619	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		73	713	7
8	36	Other	Beds	2,735	26			73		8
9	38	Medically Nec Transportation	Beds	2,735	26			73		9
10	39	Ancillary Service Centers	Beds	2,735	26			73		10
11	40	Barber and Beauty Shops	Beds	2,735	26			73		11
12	41	Coffee and Gift Shops	Beds	2,735	26			73		12
13	42	Other	Beds	2,735	26			73		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	\$		\$ 17,996	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			\$	1,820,856			\$	100,057	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								18,221	6
7													7
8													8
9	TOTAL Facility Related						\$	1,820,856			\$	123,051	9
	B. Non-Facility Related*												
10	Interest Income											(3,354)	10
11													11
12	Allocated Corporate											284	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(3,070)	14
15	TOTALS (line 9+line14)						\$	1,820,856			\$	119,981	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.)		\$	60,228	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	60,228	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.		\$	60,228	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011	60,228	12	
				13	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 Mt Zion	COUNTY	Macon
---------------	-------------------------	--------	-------

FACILITY IDPH LICENSE NUMBER 0048074

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 Applicable to Nursing Home</u>
1. 121704210003		\$ 60,228.00	\$ 60,228.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 60,228.00	\$ 60,228.00

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.**

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	73				\$ 1,076,000	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Environmental Site Study		1998		1,662					9
10	Sign		1998		1,860					10
11	Air conditioning Unit		1999		5,732					11
12	Air Conditioner		1999		750					12
13	Professional Fees --Remodeling Project		1999		15,922					13
14										14
15	Facility Remodel -- Materials		2000		241,637					15
16	Professional Fees --Remodeling Project		2000		58,519					16
17	Kitchen A/C		2000		990					17
18	Fire Alarm		2000		1,997					18
19	Door Guard System		2000		3,444					19
20										20
21	Smoke Detectors		2001		3,775					21
22	Water Main Break		2001		3,426					22
23	Commercial Disposer		2001		757					23
24	Heat Pump		2001		5,158					24
25	Carpet Extract		2001		1,206					25
26			2001							26
27	Facility Remodel -- Contractor		2001		1,397,646					27
28	Professional Fees --Remodeling Project		2001		45,077					28
29										29
30	Facility Remodel -- Contractor		2002		2,762					30
31	Fire Dampers		2002		2,766					31
32										32
33	C/O Allocation					12,349			(12,349)	33
34	Book Depreciation					178,298		178,298		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	Asphalt Sealing	2003	\$ 1,447	\$		\$	\$	\$	37
38	Sprinklers	2003	2,680						38
39	Storm Windows	2003	1,173						39
40									40
41	Water Heater	2004	1,114						41
42	Disposal	2004	871						42
43									43
44	A/C Laundry Room	2005	2,968						44
45									45
46	Sidewalk	2006	4,080						46
47	Parking Lot Sealcoat	2006	2,225						47
48	Dishroom rehab	2006	3,631						48
49	Oxygen storage room rehab	2006	3,858						49
50	Fire Alarm	2006	2,249						50
51									51
52									52
53									53
54									54
55	Storage Garage	2007	23,848						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58									58
59									59
60	Window Replacement	2009	56,034						60
61	HVAC	2009	2,656						61
62	HVAC rooftop	2009	9,250						62
63	Water Heater	2009	7,925						63
64	Parking Lot Sealcoat	2009	31,071						64
65									65
66	Water Heater	2010	16,232						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,056,165	\$ 190,647		\$ 178,298	\$ (12,349)	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,056,165	\$ 190,647		\$ 178,298	\$ (12,349)		1
2									2
3	Nurse Call & technology system	2011	184,918						3
4	Carpet	2011	9,016						4
5	Medicare lift	2011	8,334						5
6	Asbestos Abatement	2011	11,601						6
7	Heat Exchange	2011	5,637						7
8	Air Handler Unit	2011	4,714						8
9									9
10	Addison air unit	2012	2,940						10
11	Cast Iron Pipe	2012	3,208						11
12	Generator Control	2012	3,362						12
13	Nurse Call & technology system	2012	3,636						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)		\$ 3,293,531	\$ 190,647		\$ 178,298	\$ (12,349)		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		\$ 3,293,531	\$ 190,647		\$ 178,298	\$ (12,349)		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,293,531	\$ 190,647		\$ 178,298	\$ (12,349)		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		\$ 3,293,531	\$ 190,647		\$ 178,298	\$ (12,349)		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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,293,531	\$ 190,647		\$ 178,298	\$ (12,349)		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	\$669,559	\$34,557	\$34,557	\$		\$	71
72	Current Year Purchases	4,658						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$674,217	\$34,557	\$34,557	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,017,748	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$225,204	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$212,855	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(12,349)	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: \$ 6,115
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

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

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

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

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

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

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

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 231,851	\$		\$ 231,851	1
2	Licensed Speech and Language Development Therapist		hrs			89,144			89,144	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			243,876	1,729		245,605	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				308,682		308,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					19,021			19,021	13
14	TOTAL			\$		\$ 583,892	\$ 310,411		\$ 894,303	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	\$ 3,590	\$	1
2	Cash-Patient Deposits	16,029		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,343,473		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,763		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(696,533)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 671,322	\$	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)	\$ 671,322	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,029		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,619		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,397		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	Assessment Tax	96,483		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 517,294	\$	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)	\$ 517,294	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 154,028	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 671,322	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (274,540)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (274,540)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	428,568	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)	\$ 428,568	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)	\$ 154,028	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Mt Zion# 0048074Report 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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,515,801	1
2	Discounts and Allowances for all Levels	(2,047,435)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,468,366	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,958,064	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,958,064	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	739	12
13	Barber and Beauty Care	15,190	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	577,187	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 593,116	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,354	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)	\$ 5,022,900	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	816,641	31
32	Health Care	2,420,639	32
33	General Administration	988,676	33
	B. Capital Expense		
34	Ownership	352,836	34
	C. Ancillary Expense		
35	Special Cost Centers	15,540	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)*	\$ 4,594,332	40
41	Income before Income Taxes (line 30 minus line 40)**	428,568	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 428,568	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	1,952	2,032	\$ 66,074	\$ 32.52	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	9,854	10,618	267,866	25.23	3
4	Licensed Practical Nurses	11,883	12,721	276,958	21.77	4
5	CNAs & Orderlies	49,072	51,977	605,881	11.66	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,552	1,788	48,496	27.12	8
9	Activity Director					9
10	Activity Assistants	3,444	3,537	47,350	13.39	10
11	Social Service Workers	1,939	2,091	48,151	23.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,979	17,780	191,121	10.75	15
16	Dishwashers					16
17	Maintenance Workers	2,119	2,135	39,269	18.39	17
18	Housekeepers	6,817	7,303	70,759	9.69	18
19	Laundry	6,484	7,362	90,271	12.26	19
20	Administrator	1,950	2,080	84,121	40.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,571	7,104	135,068	19.01	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)	120,616	128,528	\$ 1,971,385 *	\$ 15.34	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		21,600		36
37	Medical Records Consultant		2,180		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,500		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		6,338		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 34,618		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Stephany Taylor			\$ 84,121	Workers' Compensation Insurance		\$ 54,780	IDPH License Fee		\$ 0		
				Unemployment Compensation Insurance		42,413	Advertising: Employee Recruitment		3,847		
				FICA Taxes		150,811	Health Care Worker Background Check (Indicate # of checks performed _____)		1,655		
				Employee Health Insurance		120,077	Patient Background Checks				
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*		0			13,660		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,121	Other Benefits		19,793	Dues & Subscriptions		5,863		
B. Administrative - Other				Central Office Allocation		29,176	License & Fees		7,069		
Description			Amount				Central Office Allocation		5,456		
			\$				Less: Public Relations Expense		(13,660)		
							Non-allowable advertising		(785)		
							Yellow page advertising (		)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 417,050	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 23,105		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
Vendor/Payee	Type		Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**				
Heritage Operations Group	Mgt		\$ 203,639			\$	Description				
			0				Amount				
			0				Out-of-State Travel				
							\$				
							In-State Travel				
							4,200				
							141				
							Seminar Expense				
							3,335				
							(5,677)				
Legal adj to Zero			7,451				Entertainment Expense (				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 211,090	TOTAL		\$	(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.

\$ 40,077

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.

\$ 25
- (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	3,590				1,009		1,009	PETTY C	3,590
1010	CASH IN BANK					1,100		1,100	ACCTS R	1,343,473
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	1,343,473				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	4,763
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	4,763				1,310		1,310	SUPPLIES INVENTORY	
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY	
1300	FOOD INVENTORY					1,409		1,409	LAND	0
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU	0
1409	LAND	0				1,460				0
1450	FURNITURE & EQUIPMENT	0				1,475		1,475	CODE AI	0
1460	ACCUM DEPR-FURN & EQU	0				1,490		1,490	ACCUM I	0
1475	BUILDING & IMPROVEMEN	0				1,530		1,530	RESIDEN	16,029
1490	ACCUM DEPR-BUILDING	0				1,550		1,550	LOAN FE	0
1530	RESIDENT FUNDS	16,029				1,551		1,551	LOAN FEES ADDED	
1550	LOAN FEES	0				1,850		1,850	INTERCC	(696,533)
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN	(213,766)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-696,533				2,100		2,100	ACCRUE	(92,742)
2010	ACCOUNTS PAYABLE	-213,766				2,100		2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-92,742				2,110		2,110	ACCRUE	(93,877)
2110	ACCRUED VACATION PAY	-93,877				2,120		2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(4,397)	
2125	FICA TAX PAYABLE	-4,397	-4,397	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - 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 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(96,483)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-96,483		2,400	2,400 CURRENT PORTION OF LT DI		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(16,029)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	0	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DI		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	274,540	
2460	INCOME TAXES PAYABLE					net incom	(428,568)
2512	DUE TO RESIDENTS	-16,029					
2600	MORTGAGE PAYABLE	0					
2650	EQUIPMENT LOAN PAYABLE					balance	<u>0</u>
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	274,540					
2970	PROFIT/LOSS FOR PERIOD	-428,568					
3007.1	PATIENT DAYS-PRIVATE	3,491					3,007

3007.2	PATIENT DAYS-IPA	17,473						3,007
3007.3	PATIENT DAYS-MEDICARE	4,344						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-4,488,117	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-20,984	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-577,187	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,958,064	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,047,435	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	0		6	0	6	0	3,530
3530	13 BEAUTY SHOP	-15,190		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	-345		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-394		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-6,700		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	128,618	135,068	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	84,121	84,121	17	1	0	0	4,120
4115	VACATION & SICK - G&A	6,450		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	13,238	387,874	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	2,769		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	3,786		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	17,529	17,529	21	2	0	0	4,275
4260	TELEPHONE	5,791	5,791	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	3,319	3,319	23	3	16	-1,320 **	4,280
4280	GENERAL TRAVEL	4,200	7,676	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	141		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	3,335		24	3	19	-8,414 ***	4,289
4290	HELP WANTED ADVERTISING	3,847	95,598	20	3	0	0 -40,077	4,290
4291	PROMOTIONAL ADVERTISING	23,427		20	3	25	-23,427	4,291
4292	PUBLIC RELATIONS	13,660		20	3	25	-13,660	4,292
4300	LICENSES & FEES	47,146		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	5,863		20	3	17	-785	4,310
4320	CONTRIBUTIONS	925		27	3	20	0	4,320
4350	PROFESSIONAL FEES	7,451	211,090	19	3	22	-7,451	4,350
4355	MEDICAL DIRECTOR	21,600	21,600	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSULT	2,180		10	3	0	0	4,364
4363	PHARMACIST FEES	4,500		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	6,338	6,338	12	3	0	0	4,383
4370	TV RENTAL	4,867		35	3	5	0	4,390
4380	INCOME TAXES		972	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,655		20	3	26	0	4,401
4400	PAYROLL TAXES	183,213		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	10,011		22	3	0	0	4,420
4410	GROUP INSURANCE	120,077		22	3	0	0	4,430
4420	LIABILITY INSURANCE	39,638	39,638	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	54,780		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	203,639		19	3	34	0 **	4,460
4460	BAD DEBTS	47		27	3	24	-47	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	1,248	6,115	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	37,968	39,269	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	1,301		6	1	0	0	4,510
5130	ELECTRIC	62,773	91,171	5	3	0	0	4,600
5131	NATURAL GAS	7,479		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	20,919		5	3	0	0	5,130
5134	TRASH COLLECTION	6,794	37,897	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	19,859	52,335	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	32,476		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	31,103		6	3	0	0	5,140
5210	DIETARY WAGES	187,048	191,121	1	1	0	0	5,160
5220	DIETARY SICK & VAC	4,073		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	206,030	206,005	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,934	9,157	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,374		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	4,849		1	2	0	0	5,260
5295	MEAL CREDIT	-25		2	2	0	0	5,270
5310	LAUNDRY WAGES	85,196	90,271	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	5,075		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	2,445	7,936	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,491		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	67,939	70,759	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	2,820		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	8,949	20,720	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	11,771		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,265,275	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	258,116		10	1	0	0	6,020
6030	DON WAGES	66,074		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	9,750		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	265,471		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	11,487		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	593,602		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	12,279		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	608	608	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	46,667		10	1	0	0	6,390
6275	REHAB SICK & VAC	1,829		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	105,166	125,170	10	2	0	0	7,281
6295	NURSING SUPPLIES	2,996		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	17,008		10	2	0	0	7,391
6490	NURSING OTHER	1,133	7,813	10	3	0	0	7,393
7280	DRUG PURCHASES	170,883	310,411	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	137,799		39	2			7,540
7380	LABORATORY SERVICES	19,021	583,892	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	45,567	47,350	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	1,783		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	4,031	4,031	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	243,876		39	3	0	0 ***	7,890
7660	PT SUPPLIES	1,729		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	46,002	48,151	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	2,149		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	231,851		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	89,144		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	15,540	15,540	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	328,500	328,500	34	3	0	0	

8120	INTEREST EXPENSE	18,221	18,221	32	3	14	-3,354	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-3,354		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		4,590,978	4,594,332					
			3,354					

GRAND TOTALS

-428,568

-58,458

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	3,491	3,491
IPA	17,473	17,473
medicare	4,344	4,344
		25,308

IPA BEDHOLDS

0

PP BEDHOLDS

0

PP CONVERS

0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 3,491

3,007 PATIENT	17,473
3,007 PATIENT	4,344
	0

3,010 BASIC CI	(4,488,117)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(20,984)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(577,187)
	0

3,110 PHYSICAL	(1,958,064)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

3,140 LABORATORY INCOME	
	0

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

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	1,853,220
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3,520 RENT IN	0
3,530 BEAUTY	(15,190)
	(345)
3,570 VENDIN	(394)
3,590 EQUIPM	(6,700)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	128,618
4,111 ADMINIS	84,121
4,115 G&A PTC	6,450
4,120 EMPLOY	11,735
	0
4,130 EMPLOY	2,769
4,135 EMPLOY	3,786
4,250 OFFICE S	8,310
4,255 POSTAGI	2,018
4,260 TELEPHC	5,791
4,275 TRAININ	3,319
	0
4,280 GENERA	4,200
4,281 MEAL EX	141
4,285 EDUCAT	2,546
4,289 MEETIN	789
4,290 HELP WA	3,847
4,291 PROMOT	23,427
4,292 PUBLIC I	13,660
4,300 LICENSE	47,146
4,310 DUES & F	5,863
4,320 CONTRIB	925
4,350 PROFESS	7,451
4,355 MEDICAL	21,600
	2,180
	4,500

4,364 SOCIAL S	6,338
4,370 TV RENT	4,867
4,383 BACKGR	1,655
4,390 OTHER T	0
4,400 PAYROL	183,213
4,401 PAYROL	10,011
4,410 GROUP I	120,077
4,420 LIABILIT	39,638
4,430 WORKM	50,734
4,435 W/C-FIRS	2,506
4,436 DRUG TE	1,540
4,450 MANAGI	203,639
4,460 BAD DEF	47
4,461 BAD DEF	194,215
4,470 LOST ITE	0
4,475 UNIFORM	1,503
4,486 SERVICE	14,666
4,490 MISC EX	308
4,496 MISC. M.	7,201
4,510 REAL ES	0
4,600 LEASED	1,248
5,110 MAINTEN	37,968
5,120 MAINTEN	1,301
5,130 ELECTRI	62,773
5,131 NATURA	7,479
5,133 WATER &	20,919
5,134 TRASH C	6,794
5,140 PROP/PL	19,859
5,160 GENERA	32,476
5,165 MAINTEN	16,437
5,210 DIETARY	187,048
5,220 DIETARY	4,073
5,248 FOOD PU	205,722

5,250 SUPPLIES	2,934
5,260 REPLACEMENTS	1,374
5,270 KITCHEN	4,849
5,295 MEAL IN	(25)
5,310 LAUNDRY	85,196
5,340 LAUNDRY	5,075
5,370 REPLACEMENTS	2,445
	0
5,390 SUPPLIES	5,491
5,410 HOUSEKEEPING	67,939
5,440 HOUSEKEEPING	2,820
5,480 SUPPLIES	8,949
5,490 SUPPLIES	11,771
6,020 RN WAGES	258,116
6,030 DONOR WAGES	66,074
6,035 ADONOR WAGES	0
6,040 RN PTO & OVERTIME	9,750
6,120 LPN WAGES	265,471
6,140 LPN PTO	11,487
6,220 AIDES WAGES	593,602
6,240 AIDES PTO	12,279
	0
	0
	0
	0
	608
	0
6,270 REHAB V	46,667
6,275 REHAB P	1,829
6,290 NURSING	105,166
6,295 NURSING	2,996
6,390 REPLACEMENTS	17,008
6,490 OTHER	1,133

7,280 DRUG PU	170,883
7,281 DRUG PU	137,799
7,380 LABORA	6,867
7,390 X-RAY S	4,465
	7,689
7,510 ACTIVIT	45,567
7,540 ACTIVIT	1,783
7,590 ACTIVIT	4,031
7,620 PHYSICA	243,876
7,660 P.T. SUP	1,729
7,710 SOCIAL S	46,002
7,720 SOCIAL S	2,149
7,730 SOCIAL S	0
7,740 OCCUPA	231,851
	0
7,770 SPEECH '	89,144
7,820 BEAUTIC	15,540
	0
	0
8,120 INTERES	0
	18,221
8,130 DEPRECI	0
	0
9,510 INTERES	(3,354)
9,520 MISC NO	0
4,220	0
8,100	328,500
9,702	0
5,230	0
	<u>(428,568)</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 - Danville, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Danville, IL	37-6064916001	7880
Mason City Area, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth, IL	37-0967671001	19976