

		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: 0041699

Facility Name: Heritage Health-Springfield

Address: 900 N Rutledge Springfield 62702
Number City Zip Code

County: Sangamon

Telephone Number: Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1996

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) _____ (Date) _____
(Type or Print Name) Craig Ater
(Title) Exec VP & CFO

Paid
Preparer

(Signed) _____ (Date) _____
(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-Springfield# 0041699 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>178</u>	Skilled (SNF)	<u>178</u>	<u>65,148</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>178</u>	TOTALS	<u>178</u>	<u>65,148</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>37,092</u>	<u>9,026</u>	<u>12,162</u>	<u>58,280</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>37,092</u>	<u>9,026</u>	<u>12,162</u>	<u>58,280</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.46%

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 1996

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 12,162Medicare 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	376,546	26,958		403,504		403,504	11,031	414,535			1
2	Food Purchase		438,817		438,817		438,817	81	438,898			2
3	Housekeeping	231,816	62,326		294,142		294,142		294,142			3
4	Laundry	117,007	18,788		135,795		135,795		135,795			4
5	Heat and Other Utilities			228,471	228,471		228,471	2,631	231,102			5
6	Maintenance	149,351	80,425	113,735	343,511		343,511	27,161	370,672			6
7	Other (specify):*											7
8	TOTAL General Services	874,720	627,314	342,206	1,844,240		1,844,240	40,904	1,885,144			8
	B. Health Care and Programs											
9	Medical Director			18,900	18,900		18,900	4,621	23,521			9
10	Nursing and Medical Records	3,536,453	416,395	19,094	3,971,942		3,971,942	2	3,971,944			10
10a	Therapy		1,144,772	883,921	2,028,693	(1,178,183)	850,510	(83,252)	767,258			10a
11	Activities	102,938	4,782		107,720		107,720		107,720			11
12	Social Services	55,822		4,047	59,869		59,869		59,869			12
13	CNA Training							1,841	1,841			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,695,213	1,565,949	925,962	6,187,124	(1,178,183)	5,008,941	(76,788)	4,932,153			16
	C. General Administration											
17	Administrative	68,624			68,624		68,624		68,624			17
18	Directors Fees											18
19	Professional Services			483,657	483,657		483,657	(439,938)	43,719			19
20	Dues, Fees, Subscriptions & Promotions			143,329	143,329	(97,722)	45,607	1,783	47,390			20
21	Clerical & General Office Expenses	478,367	42,319	52,657	573,343		573,343	501,092	1,074,435			21
22	Employee Benefits & Payroll Taxes			1,061,462	1,061,462		1,061,462	71,141	1,132,603			22
23	Inservice Training & Education			1,058	1,058		1,058		1,058			23
24	Travel and Seminar			4,413	4,413		4,413	(2,414)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			210,219	210,219		210,219	19,392	229,611			26
27	Other (specify):*			105,000	105,000		105,000	(105,000)				27
28	TOTAL General Administration	546,991	42,319	2,061,795	2,651,105	(97,722)	2,553,383	46,056	2,599,439			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,116,924	2,235,582	3,329,963	10,682,469	(1,275,905)	9,406,564	10,172	9,416,736			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			307,489	307,489		307,489	30,111	337,600			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,668	93,668		93,668	(20,984)	72,684			32
33	Real Estate Taxes			125,835	125,835		125,835	76	125,911			33
34	Rent-Facility & Grounds							10,891	10,891			34
35	Rent-Equipment & Vehicles			18,439	18,439		18,439	1,738	20,177			35
36	Other (specify):*											36
37	TOTAL Ownership			545,431	545,431		545,431	21,832	567,263			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					1,178,183	1,178,183		1,178,183			39
40	Barber and Beauty Shops			19,389	19,389		19,389		19,389			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,722	97,722		97,722			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			19,389	19,389	1,275,905	1,295,294		1,295,294			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,116,924	2,235,582	3,894,783	11,247,289		11,247,289	32,004	11,279,293			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(371)			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	(21,677)			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)				16
17	Non-Care Related Fees	(1,479)			17
18	Fines and Penalties				18
19	Entertainment	(9,087)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(64,441)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,000)			24
25	Fund Raising, Advertising and Promotional	(10,043)			25
	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)	\$ (212,098)		\$	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)	244,102		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 244,102		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 32,004		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

ID# 0041699
Report Period Beginning: 01/01/12
Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,479)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(64,441)	19	22
23				23
24		(105,000)	27	24
25		(10,043)	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	(180,963)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	11,031	0	0	0	0	0	0	0	0	11,031	1
2	Food Purchase	0	0	81	0	0	0	0	0	0	0	0	81	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	2,631	0	0	0	0	0	0	0	0	2,631	5
6	Maintenance	0	0	27,161	0	0	0	0	0	0	0	0	27,161	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	40,904	0	0	0	0	0	0	0	0	40,904	8
	B. Health Care and Programs													
9	Medical Director	0	0	4,621	0	0	0	0	0	0	0	0	4,621	9
10	Nursing and Medical Records	0	0	2	0	0	0	0	0	0	0	0	2	10
10a	Therapy	0	(83,252)	0	0	0	0	0	0	0	0	0	(83,252)	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	1,841	0	0	0	0	0	0	0	0	1,841	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	(83,252)	6,464	0	0	0	0	0	0	0	0	(76,788)	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	(64,441)	(404,716)	29,219	0	0	0	0	0	0	0	0	(439,938)	19
20	Fees, Subscriptions & Promotions	(11,522)	0	13,305	0	0	0	0	0	0	0	0	1,783	20
21	Clerical & General Office Expenses	0	0	501,092	0	0	0	0	0	0	0	0	501,092	21
22	Employee Benefits & Payroll Taxes	0	0	71,141	0	0	0	0	0	0	0	0	71,141	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,087)	0	6,673	0	0	0	0	0	0	0	0	(2,414)	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	19,392	0	0	0	0	0	0	0	0	19,392	26
27	Other (specify):*	(105,000)	0	0	0	0	0	0	0	0	0	0	(105,000)	27
28	TOTAL General Administration	(190,050)	(404,716)	640,822	0	0	0	0	0	0	0	0	46,056	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(190,050)	(487,968)	688,190	0	0	0	0	0	0	0	0	10,172	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%	(83,252)	(83,252)	2
3	V								3
4	V	19	Adjustment for Related Organization	404,716	Heritage Operations Group, LLC	0.00%		(404,716)	4
5	V								5
6	V	34	Adjustment for Related Organization	0	Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			\$ 404,716			\$ (83,252)	\$ * (487,968)	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.		\$	11,031	15
16	V	2	Food Purchase					81	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					2,631	19
20	V	6	Maintenance					27,161	20
21	V	7	Other					0	21
22	V	9	Medical Director					4,621	22
23	V	10	Nursing & Medical Records					2	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,841	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					29,219	31
32	V	20	Fees, Subscription, Promotions					13,305	32
33	V	21	Clerical & General Office Expenses					501,092	33
34	V	22	Employee Benefits & Payroll Taxes					71,141	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					6,673	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					19,392	38
39	Total			\$			\$ 0	\$ * 688,190	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					30,111	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					693	18
19	V	33	Real Estate Taxes					76	19
20	V	34	Rent-Facility & Grounds					11,262	20
21	V	35	Rent-Equipment & Vehicles					1,738	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	\$ * 43,880	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-Springfield # 0041699 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	178	\$ 11,031	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	178	81	2
3	3	Housekeeping	Beds	2,735	26	0	0	178	0	3
4	4	Laundry	Beds	2,735	26	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	178	2,631	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	178	27,161	6
7	7	Other	Beds	2,735	26	0	0	178	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	178	4,621	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	178	2	9
10	11	Activities	Beds	2,735	26	0	0	178	0	10
11	12	Social Service	Beds	2,735	26	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	178	1,841	12
13	14	Program Transportation	Beds	2,735	26	0	0	178	0	13
14	15	Other	Beds	2,735	26	0	0	178	0	14
15	17	Administrative	Beds	2,735	26	0	0	178	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	178	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	178	29,219	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	178	13,305	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	178	501,092	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	178	71,141	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	178	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	178	6,673	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	178	19,392	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 688,190	25

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	\$	\$	178	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		178	30,111	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			178		3
4	32	Interest	Beds	2,735	26	10,650		178	693	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		178	76	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		178	11,262	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		178	1,738	7
8	36	Other	Beds	2,735	26			178		8
9	38	Medically Nec Transportation	Beds	2,735	26			178		9
10	39	Ancillary Service Centers	Beds	2,735	26			178		10
11	40	Barber and Beauty Shops	Beds	2,735	26			178		11
12	41	Coffee and Gift Shops	Beds	2,735	26			178		12
13	42	Other	Beds	2,735	26			178		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	\$		\$ 43,880	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 Springfield		x	Mortgage			\$	1,701,632			\$	93,668	1	
2	Bank of Springfield		x	Loan Fee Amort									2	
3													3	
4													4	
5													5	
	Working Capital													
6	Bank of Springfield		xx	Working Capital									6	
7													7	
8													8	
9	TOTAL Facility Related						\$	1,701,632				\$	93,668	9
	B. Non-Facility Related*													
10	Interest Income											(21,677)	10	
11													11	
12	Allocated Corporate											693	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(20,984)	14
15	TOTALS (line 9+line14)						\$	1,701,632				\$	72,684	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.		\$	125,537	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.)		\$	122,620	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,917)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,752	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.		\$	125,835	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	116,665	8	
		2008	120,131	9	
		2009	130,175	10	
		2010	92,106	11	
		2011	125,835	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-Springfield

COUNTY
Sangamon

FACILITY IDPH LICENSE NUMBER
0041699

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 14280277027		\$ 122,620.00	\$ 122,620.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 122,620.00	\$ 122,620.00

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:

38,805

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				\$ 630,000	1
2					2
3	TOTALS			\$ 630,000	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	178				\$ 1,900,000	\$		\$	\$	4
5					1,648,258					5
6										6
7										7
8										8
	Improvement Type**									
9	1985 Improvements		1985		26,076					9
10	1986 Improvements		1986		216,545					10
11	1987 Improvements		1987		593,121					11
12	1988 Improvements		1988		29,321					12
13	1989 Improvements		1989		1,095					13
14	1990 Improvements		1990		939					14
15	1991 Improvements		1991		32,022					15
16	1992 Improvements		1992		32,593					16
17	1993 Improvements		1993		105,986					17
18	1994 Improvements		1994		59,542					18
19	1995 Improvements		1995		36,126					19
20	Laundry Chute		1996		4,926					20
21	Door Alarm		1996		8,533					21
22	Garbage Disposal		1996		1,113					22
23	Elevator		1996		11,439					23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33	C/O Allocation					30,111			(30,111)	33
34	Book Depreciation					249,072		249,072		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	Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,668,973	\$ 279,183		\$ 249,072	\$ (30,111)	\$	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		\$ 5,668,973	\$ 279,183		\$ 249,072	\$ (30,111)	\$	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11									11
12	Door Replacement	2003	1,216						12
13									13
14									14
15	Shower Room Remodel	2003	14,285						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	36,919						19
20	Elevator Repair	2004	74,457						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24	Controller board	2005	2,460						24
25	Wall Railing	2005	2,837						25
26	A/C Protection	2005	1,318						26
27	Compressor	2005	10,800						27
28	Chiller	2005	2,305						28
29	Rooftop Compressor	2005	4,676						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,050,204	\$ 279,183		\$ 249,072	\$ (30,111)	\$	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		\$ 6,050,204	\$ 279,183		\$ 249,072	\$ (30,111)	\$	1
2	Sprinkler system	2006	250,656						2
3	Door Alarm	2006	2,940						3
4	Stair Treads	2006	12,497						4
5	Roof	2006	2,219						5
6	Fire door	2006	6,154						6
7									7
8	HVAC Controls								8
9		2007	12,375						9
10	Sprinkler system	2007							10
11	Circulating pump	2007	12,140						11
12		2007	2,693						12
13	Walk-in freezer	2007							13
14	Fire Alarm	2007	24,013						14
15	Exit Lighting	2007							15
16		2007							16
17	HVAC								17
18		2007	18,080						18
19	Window treatments	2007							19
20		2007	3,431						20
21	Beauty Shop sink, vanity, painting								21
22		2008	1,597						22
23									23
24	HVAC								24
25	Elevator	2009	11,480						25
26	Boiler	2009	53,743						26
27	Asphalt	2009	2,914						27
28		2009	9,138						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,476,274	\$ 279,183		\$ 249,072	\$ (30,111)	\$	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		\$ 6,476,274	\$ 279,183		\$ 249,072	\$ (30,111)	\$	1
2									2
3	Elevator	2010	71,294						3
4	Water storage tank	2010	16,211						4
5	paging system	2010	2,642						5
6	water heater	2010	13,740						6
7	dinning room window	2010	49,757						7
8	fire rated metal	2010	3,921						8
9	Aggregate column	2010	34,550						9
10	boiler	2010	3,255						10
11									11
12	100 gallon water heater	2011	8,958						12
13	Chiller	2011	11,556						13
14	Door & Installation	2011	4,361						14
15	Chiller Fan	2011	3,792						15
16	Smoke detector	2011	3,935						16
17	Sign	2011	3,250						17
18									18
19	Lighting upgrade	2012	22,896						19
20	Nurse Call	2012	5,107						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)		\$ 6,735,499	\$ 279,183		\$ 249,072	\$ (30,111)	\$	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	\$1,622,160	\$58,417	\$58,417	\$		\$	71
72	Current Year Purchases	39,482						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,661,642	\$58,417	\$58,417	\$		\$	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		2008 Van		\$38,949	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$38,949	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,066,09081
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$337,60082
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$307,48983**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(30,111)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

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\$

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: \$18,439

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

* 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	\$		\$ 385,464	\$		\$ 385,464	1
2	Licensed Speech and Language Development Therapist		hrs			72,355			72,355	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			391,707	984		392,691	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				1,143,788		1,143,788	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					34,395			34,395	13
14	TOTAL			\$		\$ 883,921	\$ 1,144,772		\$ 2,028,693	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 351,511	\$	1
2	Cash-Patient Deposits	23,928		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,610,659		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,555		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,640,697		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,711,350	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	6,841,766		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,700,590		16
17	Accumulated Depreciation (book methods)	(5,521,556)		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)	\$ 3,650,800	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,362,150	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 644,199	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,928		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	1,701		31
32	Accrued Real Estate Taxes(Sch.IX-B)	128,752		32
33	Accrued Interest Payable	6,511		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Assessment Tax</u>	211,442		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,016,533	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,701,632		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)	\$ 1,701,632	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,718,165	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,643,985	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,362,150	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,019,966	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,019,966	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	624,019	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)	\$ 624,019	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)	\$ 5,643,985	24 *

* This must agree with page 17, line 47.

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,337,490	1
2	Discounts and Allowances for all Levels	(5,063,013)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,274,477	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,453,725	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,453,725	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	16,291	12
13	Barber and Beauty Care	21,320	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	371	16
17	Sale of Drugs	2,086,116	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(140)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,123,958	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,677	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,677	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(828)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (828)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,873,009	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,844,240	31
32	Health Care	6,187,124	32
33	General Administration	2,651,105	33
	B. Capital Expense		
34	Ownership	545,431	34
	C. Ancillary Expense		
35	Special Cost Centers	19,389	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)*	\$ 11,247,289	40
41	Income before Income Taxes (line 30 minus line 40)**	625,720	41
42	Income Taxes	(1,701)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 624,019	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	1,784	2,024	\$ 69,758	\$ 34.47	1
2	Assistant Director of Nursing	526	526	19,162	36.43	2
3	Registered Nurses	23,198	25,806	651,467	25.24	3
4	Licensed Practical Nurses	49,465	53,257	1,153,064	21.65	4
5	CNAs & Orderlies	120,539	128,858	1,643,002	12.75	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	8,887	9,712	102,938	10.60	10
11	Social Service Workers	3,577	4,192	55,822	13.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,095	38,563	376,546	9.76	15
16	Dishwashers					16
17	Maintenance Workers	10,896	11,640	149,351	12.83	17
18	Housekeepers	21,032	22,874	231,816	10.13	18
19	Laundry	10,853	11,945	117,007	9.80	19
20	Administrator	1,950	2,080	68,624	32.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,565	23,025	478,367	20.78	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)	309,367	334,502	\$ 5,116,924 *	\$ 15.30	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		18,900		36
37	Medical Records Consultant		810		37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,680		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		4,047		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 34,437		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				
Keil Perigan			\$ 68,624	Workers' Compensation Insurance		\$ 133,186	IDPH License Fee		\$ 0				
				Unemployment Compensation Insurance		106,971	Advertising: Employee Recruitment		3,535				
				FICA Taxes		391,445	Health Care Worker Background Check						
				Employee Health Insurance		409,870	(Indicate # of checks performed _____)		6,158				
				Employee Meals			Patient Background Checks						
				Illinois Municipal Retirement Fund (IMRF)*		0			7,489				
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		19,990	Dues & Subscriptions		20,397				
(List each licensed administrator separately.)			\$ 68,624	Central Office Allocation		71,141	License & Fees		5,474				
B. Administrative - Other							Central Office Allocation		13,305				
Description			Amount				Less: Public Relations Expense		(7,489)				
			\$				Non-allowable advertising		(1,479)				
							Yellow page advertising	(	)				
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 47,390				
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,132,603						
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees						G. Schedule of Travel and Seminar**			
C. Professional Services				Description		Line #	Amount		Description		Amount		
Vendor/Payee	Type		Amount				\$		Out-of-State Travel	\$			
Heritage Operations Group	Mgt		\$ 404,716										
Sulaski & Webb	Audit		14,500										
			0						In-State Travel				
Legal adj to Zero			64,441						Seminar Expense		2,429		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense		(	)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 483,657					(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.

\$ 97,722

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.

\$ 3,312

(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	351,511				1,009		1,009	PETTY C 351,511
1010	CASH IN BANK					1,100		1,100	ACCTS R 2,610,659
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	2,610,659				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 84,555
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	84,555				1,310		1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY
1300	FOOD INVENTORY					1,409		1,409	LAND 630,000
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU 1,700,590
1409	LAND	630,000				1,460			(1,461,333)
1450	FURNITURE & EQUIPMENT	1,700,590				1,475		1,475	CODE AI 6,841,766
1460	ACCUM DEPR-FURN & EQU	-1,461,333				1,490		1,490	ACCUM I (4,060,223)
1475	BUILDING & IMPROVEMEN	6,841,766				1,530		1,530	RESIDEN 23,928
1490	ACCUM DEPR-BUILDING	-4,060,223				1,550		1,550	LOAN FE 0
1530	RESIDENT FUNDS	23,928				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	0				1,850		1,850	INTERCC 1,640,697
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN (644,199)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	1,640,697				2,100		2,100	ACCRUE 0
2010	ACCOUNTS PAYABLE	-644,199				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	0				2,110		2,110	ACCRUE 0
2110	ACCRUED VACATION PAY	0				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(1,701)	
2125	FICA TAX PAYABLE	-1,701	-1,701	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	(6,511)	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(211,442)	
2300	ACCRUED INTEREST PAYA	-6,511		2,350	2,350 REAL ES	(128,752)	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-211,442		2,400	2,400 CURRENT PORTION OF LT DI		
2350	REAL ESTATE TAX PAYAB	-128,752		2,512	2,512 DUE TO I	(23,928)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(1,701,632)	
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 RETAINI	(5,019,966)	
2460	INCOME TAXES PAYABLE					net incom	(624,019)
2512	DUE TO RESIDENTS	-23,928					
2600	MORTGAGE PAYABLE	-1,701,632					
2650	EQUIPMENT LOAN PAYABLE					balance	<u>0</u>
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-5,019,966					
2970	PROFIT/LOSS FOR PERIOD	-624,019					
3007.1	PATIENT DAYS-PRIVATE	9,026					3,007

3007.2	PATIENT DAYS-IPA	37,092					3,007
3007.3	PATIENT DAYS-MEDICARE	12,162					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 & -11,140,486		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	-158,825	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	-2,086,116	0	0	0	0	3,101
3101	17 DRUGS-OTHER						3,110
3110	6 PT-PRIVATE	-3,453,725	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	5,063,013	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	-371		6	0	6	-371	3,530
3530	13 BEAUTY SHOP	-21,320		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	-14,004		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-2,287		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-38,179		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	80		0	0	0	0	4,110
3600	21 MISC INCOME	60		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	444,040	478,367	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	68,624	68,624	17	1	0	0	4,120
4115	VACATION & SICK - G&A	34,327		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	16,510	1,061,462	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	3,480		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	42,319	42,319	21	2	0	0	4,275
4260	TELEPHONE	52,657	52,657	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	1,058	1,058	23	3	16	0 **	4,280
4280	GENERAL TRAVEL	1,718	4,413	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	266		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	2,429		24	3	19	-9,087 ***	4,289
4290	HELP WANTED ADVERTISING	3,535	143,329	20	3	0	0 -97,722	4,290
4291	PROMOTIONAL ADVERTISING	2,554		20	3	25	-2,554	4,291
4292	PUBLIC RELATIONS	7,489		20	3	25	-7,489	4,292
4300	LICENSES & FEES	103,196		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	20,397		20	3	17	-1,479	4,310
4320	CONTRIBUTIONS	0		27	3	20	0	4,320
4350	PROFESSIONAL FEES	78,941	483,657	19	3	22	-64,441	4,350
4355	MEDICAL DIRECTOR	18,900	18,900	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	810		10	3	0	0	4,364
4363	PHARMACIST FEES	10,680		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	4,047	4,047	12	3	0	0	4,383
4370	TV RENTAL	2,298		35	3	5	0	4,390
4380	INCOME TAXES		105,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	6,158		20	3	26	0	4,401
4400	PAYROLL TAXES	491,293		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	7,123		22	3	0	0	4,420
4410	GROUP INSURANCE	409,870		22	3	0	0	4,430
4420	LIABILITY INSURANCE	210,219	210,219	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	133,186		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	404,716		19	3	34	0 **	4,460
4460	BAD DEBTS	105,000		27	3	24	-105,000	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	125,835	125,835	33	3	0	0	4,486
4600	LEASED EQUIPMENT	16,141	18,439	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	140,545	149,351	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	8,806		6	1	0	0	4,510
5130	ELECTRIC	148,629	228,471	5	3	0	0	4,600
5131	NATURAL GAS	32,947		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	46,895		5	3	0	0	5,130
5134	TRASH COLLECTION	49,384	113,735	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	30,322	80,425	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	50,103		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	64,351		6	3	0	0	5,140
5210	DIETARY WAGES	365,004	376,546	1	1	0	0	5,160
5220	DIETARY SICK & VAC	11,542		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	442,129	438,817	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	6,373	26,958	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,710		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	16,875		1	2	0	0	5,260
5295	MEAL CREDIT	-3,312		2	2	0	0	5,270
5310	LAUNDRY WAGES	112,061	117,007	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,946		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	8,533	18,788	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	10,255		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	219,154	231,816	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	12,662		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	24,229	62,326	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	38,097		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		3,536,453	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	618,825		10	1	0	0	6,020
6030	DON WAGES	69,758		10	1	0	0	6,030
6035	ADON	19,162		10	1	0	0	6,035
6040	RN SICK & VACATION	32,642		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	1,110,680		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	42,384		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	1,578,224		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	64,778		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	50,697	416,395	10	2	0	0	7,281
6295	NURSING SUPPLIES	358,818		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	6,880		10	2	0	0	7,391
6490	NURSING OTHER	7,604	19,094	10	3	0	0	7,393
7280	DRUG PURCHASES	817,305	1,144,772	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	326,483		39	2			7,540
7380	LABORATORY SERVICES	34,395	883,921	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	97,086	102,938	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,852		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	4,782	4,782	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	391,707		39	3	0	0 ***	7,890
7660	PT SUPPLIES	984		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	53,840	55,822	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,982		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	385,464		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	72,355		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	19,389	19,389	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	0	0	34	3	0	0	

8120	INTEREST EXPENSE	93,668	93,668	32	3	14	-21,677	
8130	DEPRECIATION	307,489	307,489	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-21,677		32	0	10	0	
9520	MISC NON-OPERATING INC	1,701		0	0	0	0	
9700	INCOME TAXES	828		0	0	0	0	
		11,228,141	11,247,289					
			19,148					

GRAND TOTALS

-624,019

(NET INCOME)

-212,098

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	9,026	9,026
IPA	37,092	37,092
medicare	12,162	12,162
		58,280
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT

9,026

3,007 PATIENT	37,092
3,007 PATIENT	12,162
	0
3,010 BASIC CI	(11,140,486)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(158,825)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(2,086,116)
	0
3,110 PHYSICAL	(3,453,725)
	0
3,112 PHYSICAL	0
3,113 PHYSICAL	0
3,140 LABORATORY INCOME	
	0
3,152 ST/OT TR	0
3,153 ST/OT TR	0
3,185 REHAB/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	4,951,637

3,520 RENT IN	(371)
3,530 BEAUTY	(21,320)
	(14,004)
3,570 VENDIN	(2,287)
3,590 EQUIPM	(38,179)
3,595 RESIDEN	80
3,600 MISC INC	60
4,110 G&A WA	444,040
4,111 ADMINIS	68,624
4,115 G&A PTC	34,327
4,120 EMPLOY	15,871
	0
4,130 EMPLOY	0
4,135 EMPLOY	3,480
4,250 OFFICE S	24,570
4,255 POSTAGI	6,477
4,260 TELEPHC	52,657
4,275 TRAININ	1,058
	(18)
4,280 GENERA	1,718
4,281 MEAL EX	266
4,285 EDUCAT	2,429
4,289 MEETIN	0
4,290 HELP WA	3,535
4,291 PROMOT	2,554
4,292 PUBLIC I	7,489
4,300 LICENSE	103,196
4,310 DUES & S	20,397
4,320 CONTRIE	0
4,350 PROFESS	78,941
4,355 MEDICAL	18,900
	810
	10,680

4,364 SOCIAL S	4,047
4,370 TV RENT	2,298
4,383 BACKGR	6,158
4,390 OTHER T	853
4,400 PAYROL	491,293
4,401 PAYROL	7,123
4,410 GROUP I	409,870
4,420 LIABILIT	210,219
4,430 WORKM	125,743
4,435 W/C-FIRS	2,421
4,436 DRUG TE	5,040
4,450 MANAGI	404,716
4,460 BAD DEF	105,000
4,461 BAD DEF	111,376
4,470 LOST ITE	0
4,475 UNIFORM	639
4,486 SERVICE	28,317
4,490 MISC EX	2,073
4,496 MISC. M.	11,272
4,510 REAL ES	125,835
4,600 LEASED	16,141
5,110 MAINTEN	140,545
5,120 MAINTEN	8,806
5,130 ELECTRI	148,629
5,131 NATURA	32,947
5,133 WATER &	46,895
5,134 TRASH C	49,384
5,140 PROP/PL	30,322
5,160 GENERA	50,103
5,165 MAINTEN	36,034
5,210 DIETARY	365,004
5,220 DIETARY	11,542
5,248 FOOD PU	440,056

5,250 SUPPLIES	6,373
5,260 REPLACEMENTS	3,710
5,270 KITCHEN	16,875
5,295 MEAL IN	(3,312)
5,310 LAUNDRY	112,061
5,340 LAUNDRY	4,946
5,370 REPLACEMENTS	8,533
	0
5,390 SUPPLIES	10,255
5,410 HOUSEKEEPING	219,154
5,440 HOUSEKEEPING	12,662
5,480 SUPPLIES	24,229
5,490 SUPPLIES	38,097
6,020 RN WAGES	618,825
6,030 DONOR WAGES	69,758
6,035 ADONOR WAGES	19,162
6,040 RN PTO & OVERTIME	32,642
6,120 LPN WAGES	1,110,680
6,140 LPN PTO	42,384
6,220 AIDES WAGES	1,578,224
6,240 AIDES PTO	64,778
	0
	0
	0
	0
	0
	0
	0
6,270 REHABILITATION	0
6,275 REHABILITATION	0
6,290 NURSING	50,697
6,295 NURSING	358,818
6,390 REPLACEMENTS	6,880
6,490 OTHER	7,604

7,280 DRUG PU	817,305
7,281 DRUG PU	326,483
7,380 LABORA	16,799
7,390 X-RAY S	10,081
	7,515
7,510 ACTIVIT	97,086
7,540 ACTIVIT	5,852
7,590 ACTIVIT	4,782
7,620 PHYSICA	391,707
7,660 P.T. SUP	984
7,710 SOCIAL S	53,840
7,720 SOCIAL S	1,982
7,730 SOCIAL S	0
7,740 OCCUPA	385,464
	0
7,770 SPEECH '	72,355
7,820 BEAUTIC	19,389
	0
	0
8,120 INTERES	93,668
	0
8,130 DEPRECI	307,489
	0
9,510 INTERES	(21,677)
9,520 MISC NO	(25)
4,220	0
8,100	0
9,702	1,701
5,230	0
	<u>(624,019)</u>

Expenses Fixed Assets

FACILITY	MEDICAID	STATE
Owned SNFs	NUMBER	LICENSE
NUMBER	NUMBER	
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, IL	37-0967671001	19976