

		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: 0048066

Facility Name: Heritage Health-Streator

Address: 1525 E Main St Streator 61364
Number City Zip Code

County: LaSalle

Telephone Number: (815) 672-4516 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

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

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

GOVERNMENTAL
State
County
Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heritage Health-Streator# 0048066 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>130</u>	Skilled (SNF)	<u>130</u>	<u>47,580</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>130</u>	TOTALS	<u>130</u>	<u>47,580</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>24,779</u>	<u>12,555</u>	<u>7,342</u>	<u>44,676</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>24,779</u>	<u>12,555</u>	<u>7,342</u>	<u>44,676</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.90%

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 July 2006

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 7,342Medicare 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	538,606	27,228		565,834		565,834	8,057	573,891			1
2	Food Purchase		90,702		90,702		90,702	59	90,761			2
3	Housekeeping	162,149	45,362		207,511		207,511		207,511			3
4	Laundry	72,745	26,656		99,401		99,401		99,401			4
5	Heat and Other Utilities			141,389	141,389		141,389	1,922	143,311			5
6	Maintenance	91,865	88,869	53,273	234,007		234,007	19,836	253,843			6
7	Other (specify):*											7
8	TOTAL General Services	865,365	278,817	194,662	1,338,844		1,338,844	29,874	1,368,718			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400	3,375	5,775			9
10	Nursing and Medical Records	2,553,220	254,963	13,354	2,821,537		2,821,537	2	2,821,539			10
10a	Therapy		630,227	665,182	1,295,409	(662,292)	633,117	63,906	697,023			10a
11	Activities	86,913	6,702		93,615		93,615		93,615			11
12	Social Services	33,878	45	3,168	37,091		37,091		37,091			12
13	CNA Training	15,663	600		16,263		16,263	1,345	17,608			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,689,674	892,537	684,104	4,266,315	(662,292)	3,604,023	68,628	3,672,651			16
	C. General Administration											
17	Administrative	94,614			94,614		94,614		94,614			17
18	Directors Fees											18
19	Professional Services			379,527	379,527		379,527	(358,187)	21,340			19
20	Dues, Fees, Subscriptions & Promotions			119,910	119,910	(71,370)	48,540	(15,532)	33,008			20
21	Clerical & General Office Expenses	233,495	29,697	5,697	268,889		268,889	365,966	634,855			21
22	Employee Benefits & Payroll Taxes			792,083	792,083		792,083	51,957	844,040			22
23	Inservice Training & Education			8,710	8,710		8,710	(6,711)	1,999			23
24	Travel and Seminar			10,664	10,664		10,664	(8,665)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,248	62,248		62,248	14,163	76,411			26
27	Other (specify):*			3,988	3,988		3,988		3,988			27
28	TOTAL General Administration	328,109	29,697	1,382,827	1,740,633	(71,370)	1,669,263	42,991	1,712,254			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,883,148	1,201,051	2,261,593	7,345,792	(733,662)	6,612,130	141,493	6,753,623			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							260,883	260,883			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,616	31,616		31,616	149,719	181,335			32
33	Real Estate Taxes							64,422	64,422			33
34	Rent-Facility & Grounds			569,400	569,400		569,400	(561,175)	8,225			34
35	Rent-Equipment & Vehicles			16,116	16,116		16,116	1,269	17,385			35
36	Other (specify):*											36
37	TOTAL Ownership			617,132	617,132		617,132	(84,882)	532,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					662,292	662,292		662,292			39
40	Barber and Beauty Shops		1,185	18,457	19,642		19,642		19,642			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					71,370	71,370		71,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,185	18,457	19,642	733,662	753,304		753,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,883,148	1,202,236	2,897,182	7,982,566		7,982,566	56,611	8,039,177			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	(1,485)			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)	(6,711)			16
17	Non-Care Related Fees	(1,179)			17
18	Fines and Penalties				18
19	Entertainment	(13,539)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,945)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,070)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,929)		\$	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)	106,540		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 106,540		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 56,611		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-Streator

Report Period Beginning: ID# 0048066
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		(1,179)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,945)	19	22
23				23
24		0	27	24
25		(24,070)	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	(28,194)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Streator # 0048066 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	8,057	0	0	0	0	0	0	0	0	8,057	1
2	Food Purchase	0	0	59	0	0	0	0	0	0	0	0	59	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	1,922	0	0	0	0	0	0	0	0	1,922	5
6	Maintenance	0	0	19,836	0	0	0	0	0	0	0	0	19,836	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	29,874	0	0	0	0	0	0	0	0	29,874	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,375	0	0	0	0	0	0	0	0	3,375	9
10	Nursing and Medical Records	0	0	2	0	0	0	0	0	0	0	0	2	10
10a	Therapy	0	63,906	0	0	0	0	0	0	0	0	0	63,906	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	1,345	0	0	0	0	0	0	0	0	1,345	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	63,906	4,722	0	0	0	0	0	0	0	0	68,628	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	(2,945)	(376,582)	21,340	0	0	0	0	0	0	0	0	(358,187)	19
20	Fees, Subscriptions & Promotions	(25,249)	0	9,717	0	0	0	0	0	0	0	0	(15,532)	20
21	Clerical & General Office Expenses	0	0	365,966	0	0	0	0	0	0	0	0	365,966	21
22	Employee Benefits & Payroll Taxes	0	0	51,957	0	0	0	0	0	0	0	0	51,957	22
23	Inservice Training & Education	(6,711)	0	0	0	0	0	0	0	0	0	0	(6,711)	23
24	Travel and Seminar	(13,539)	0	4,874	0	0	0	0	0	0	0	0	(8,665)	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	14,163	0	0	0	0	0	0	0	0	14,163	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(48,444)	(376,582)	468,017	0	0	0	0	0	0	0	0	42,991	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(48,444)	(312,676)	502,613	0	0	0	0	0	0	0	0	141,493	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%	63,906	63,906	2
3	V								3
4	V	19	Adjustment for Related Organization	376,582	Heritage Operations Group, LLC	0.00%		(376,582)	4
5	V								5
6	V	34	Adjustment for Related Organization	569,400	Heritage Manor Real Estate, LLC	0.00%		(569,400)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		64,367	64,367	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		145,925	145,925	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		238,892	238,892	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			\$ 945,982			\$ 517,863	\$ * (428,119)	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.		\$	8,057	15
16	V	2	Food Purchase					59	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,922	19
20	V	6	Maintenance					19,836	20
21	V	7	Other					0	21
22	V	9	Medical Director					3,375	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					1,345	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					21,340	31
32	V	20	Fees, Subscription, Promotions					9,717	32
33	V	21	Clerical & General Office Expenses					365,966	33
34	V	22	Employee Benefits & Payroll Taxes					51,957	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					4,874	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					14,163	38
39	Total			\$			\$ 0	\$ * 502,613	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					21,991	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					506	18
19	V	33	Real Estate Taxes					55	19
20	V	34	Rent-Facility & Grounds					8,225	20
21	V	35	Rent-Equipment & Vehicles					1,269	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	\$ * 32,046	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-Streator # 0048066 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	130	\$ 8,057	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	130	59	2
3	3	Housekeeping	Beds	2,735	26	0	0	130	0	3
4	4	Laundry	Beds	2,735	26	0	0	130	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	130	1,922	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	130	19,836	6
7	7	Other	Beds	2,735	26	0	0	130	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	130	3,375	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	130	2	9
10	11	Activities	Beds	2,735	26	0	0	130	0	10
11	12	Social Service	Beds	2,735	26	0	0	130	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	130	1,345	12
13	14	Program Transportation	Beds	2,735	26	0	0	130	0	13
14	15	Other	Beds	2,735	26	0	0	130	0	14
15	17	Administrative	Beds	2,735	26	0	0	130	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	130	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	130	21,340	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	130	9,717	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	130	365,966	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	130	51,957	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	130	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	130	4,874	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	130	14,163	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 502,613	25

Facility Name & ID Number Heritage Health-Streator # 0048066 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	\$	\$	130	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		130	21,991	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			130		3
4	32	Interest	Beds	2,735	26	10,650		130	506	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		130	55	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		130	8,225	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		130	1,269	7
8	36	Other	Beds	2,735	26			130		8
9	38	Medically Nec Transportation	Beds	2,735	26			130		9
10	39	Ancillary Service Centers	Beds	2,735	26			130		10
11	40	Barber and Beauty Shops	Beds	2,735	26			130		11
12	41	Coffee and Gift Shops	Beds	2,735	26			130		12
13	42	Other	Beds	2,735	26			130		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	\$		\$ 32,046	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			\$	2,657,269			\$	145,925	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								31,616	6						
7													7						
8													8						
9	TOTAL Facility Related						\$	2,657,269				\$	182,314	9					
	B. Non-Facility Related*																		
10	Interest Income											(1,485)	10						
11													11						
12	Allocated Corporate											506	12						
13													13						
14	TOTAL Non-Facility Related						\$					\$	(979)	14					
15	TOTALS (line 9+line14)						\$	2,657,269				\$	181,335	15					

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$64,367	2
3. Under or (over) accrual (line 2 minus line 1).			\$64,367	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.			\$64,367	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2007 8 2008 9 2009 10 2010 11 2011 64,367 12	FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2011 \$	13
			14 PLUS APPEAL COST FROM LINE 5 \$	14
			15 LESS REFUND FROM LINE 6 \$	15
			16 AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Heritage Health-Streator</u>	COUNTY	<u>LaSalle</u>
---------------	---------------------------------	--------	----------------

FACILITY IDPH LICENSE NUMBER 0048066

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	3431134000		\$ 64,367.00	\$ 64,367.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 64,367.00	\$ 64,367.00

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:	19,262	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				\$ 17,000	1
2					2
3	TOTALS			\$ 17,000	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	130				\$ 348,848	\$		\$	\$	4
5					440,122					5
6					2,594,839					6
7										7
8										8
	Improvement Type**									
9	1978 Improvements		1980		12,172					9
10	1979 Improvements		1981		13,748					10
11	1980 Improvements		1982		18,366					11
12	1981 Improvements		1983		9,250					12
13	1982 Improvements		1984		1,329					13
14	1983 Improvements		1985		4,100					14
15	1984 Improvements		1986		57,336					15
16	1985 Improvements		1987		6,225					16
17	1986 Improvements		1988		48,818					17
18	1988 Improvements		1989		22,687					18
19	1989 Improvements		1990		31,584					19
20	1990 Improvements		1991		3,560					20
21	1991 Improvements		1992		19,172					21
22	1992 Improvements		1993		23,135					22
23	1993 Improvements		1994		22,036					23
24	1994 Improvements		1995		39,228					24
25	1995 Improvements		1996		3,910					25
26	BOILER									26
27	EXHAUST HOOD									27
28	CODE ALERT									28
29	PHONE SYSTEM									29
30	INTERIOR REMODEL									30
31										31
32										32
33	C/O Allocation					21,991			(21,991)	33
34	Book Depreciation					164,217		164,217		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	Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$	37
38	Roof	1997	5,232						38
39	Sprinkler System	1997	9,530						39
40	Code Alert	1997	1,879						40
41									41
42	Code Alert	1998	2,000						42
43	Bathroom Door	1998	656						43
44	Interior Rehab	1998	11,815						44
45									45
46	Door Alarms	1999	3,675						46
47									47
48	Water Heater	2000	4,114						48
49	Exhaust Fans	2000	931						49
50	Booster Heater -- Water Heater	2000	1,465						50
51									51
52	Professional Fees---Building Renovation	2001	27,964						52
53	Sprinkler Replacement	2001	4,955						53
54	AC Unit with Installation	2001	4,372						54
55	Exterior Painting	2001	6,545						55
56	Code Alert System	2001	4,592						56
57									57
58	Roof	2002	48,840						58
59	Sewer line	2002	20,615						59
60	Condensing Unit	2002	1,213						60
61									61
62	Exterior Door	2003	6,556						62
63	Exit Lights	2003	1,013						63
64	Heating Pump	2003	1,746						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,177,147	\$ 186,208		\$ 164,217	\$ (21,991)	\$	70

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

Facility Name & ID Number Heritage Health-Streator

0048066

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,177,147	\$ 186,208		\$ 164,217	\$ (21,991)	\$	1
2	Doors	2004	1,386						2
3	A/C	2004	5,061						3
4	PVC kickplate	2004	2,859						4
5	Disposal	2004	1,175						5
6									6
7	Roof	2005	54,596						7
8	A/C Condensing Unit	2005	5,800						8
9	Window Replacement	2005	51,893						9
10	Water Main	2005	1,706						10
11									11
12									12
13	Roof	2006	19,500						13
14	A/C Replacement	2006	1,974						14
15	Boiler	2006	58,327						15
16	Landscapping	2006	5,398						16
17									17
18	Nurse's station	2007	9,580						18
19	Nurse call system	2007	96,193						19
20	Wireless network	2007	26,272						20
21	Corridor Paint and floors	2007	37,819						21
22	A/C	2007	23,747						22
23	Wander guard	2007	4,177						23
24	Garage --Construction of new Maintenance Garage	2007	42,453						24
25	Professional Fee -- remodel	2007	1,286						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,628,349	\$ 186,208		\$ 164,217	\$ (21,991)	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,628,349	\$ 186,208		\$ 164,217	\$ (21,991)	\$	1
2	Landscaping	2008	22,238						2
3	Garage --Construction of new Maintenance Garage	2008	9,644						3
4	South Wing Windows	2008	63,040						4
5	Air Handler	2008	10,301						5
6	Redo North Nurses Station	2008	8,101						6
7									7
8	Wireless Network	2009	4,035						8
9	South Dining Room Electric	2009	2,752						9
10	Corridor Doors	2009	22,230						10
11									11
12	Lennox condensor	2010	6,864						12
13	Walkin Cooler	2010	4,313						13
14	Nurse Call System	2010	6,594						14
15	Wood Blinds	2010	2,914						15
16									16
17									17
18	Trane Air Handler	2011	58,281						18
19	Trane Rooftop Unit	2011	3,017						19
20	Gas Water Heater	2011	4,352						20
21	Air Condition Coils	2011	7,904						21
22	Water Heater	2011	4,352						22
23	Wiring & Installation	2011	7,546						23
24	Sealer & Coating	2011	8,985						24
25	Sign	2011	2,650						25
26									26
27	Goodman Condensing Unit	2012	9,494						27
28	Flooring Replacement	2012	176,220						28
29	GFI & Receptical	2012	4,158						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,078,334	\$ 186,208		\$ 164,217	\$ (21,991)	\$	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		\$ 5,078,334	\$ 186,208		\$ 164,217	\$ (21,991)		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,078,334	\$ 186,208		\$ 164,217	\$ (21,991)		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	\$1,271,835	\$74,675	\$74,675	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,271,835	\$74,675	\$74,675	\$		\$	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)	\$6,367,169	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$260,883	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$238,892	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(21,991)	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?
16. Rental Amount for movable equipment: \$16,116 Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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 EndingAnnual Rent
12. /2013 \$
13. /2014 \$
14. /2015 \$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		600		600
3	Classroom Wages (a)				
4	Clinical Wages (b)		15,663		15,663
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 16,263	\$	\$ 16,263
10	SUM OF line 9, col. 1 and 2 (e)	\$	16,263		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 306,389	\$		\$ 306,389	1
2	Licensed Speech and Language Development Therapist		hrs			35,816			35,816	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			288,311	2,601		290,912	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				627,626		627,626	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					34,666			34,666	13
14	TOTAL			\$		\$ 665,182	\$ 630,227		\$ 1,295,409	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	\$ 3,203	\$	1
2	Cash-Patient Deposits	9,558		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,903,793		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,953		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(764,034)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,188,473	\$	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)	\$ 1,188,473	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 339,899	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,558		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	431,278		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,875		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Assessment Tax</u>	172,103		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 960,713	\$	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)	\$ 960,713	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 227,760	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,188,473	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (475,021)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (475,021)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	702,781	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)	\$ 702,781	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)	\$ 227,760	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	\$ 8,078,969	1
2	Discounts and Allowances for all Levels	(2,868,842)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,210,127	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,260,081	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,260,081	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	1,131	12
13	Barber and Beauty Care	25,994	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,164,419	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	22,110	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,213,654	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,485	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,485	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)	\$ 8,685,347	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,338,844	31
32	Health Care	4,266,315	32
33	General Administration	1,740,633	33
	B. Capital Expense		
34	Ownership	617,132	34
	C. Ancillary Expense		
35	Special Cost Centers	19,642	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)*	\$ 7,982,566	40
41	Income before Income Taxes (line 30 minus line 40)**	702,781	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 702,781	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	1,853	2,033	\$ 68,999	\$ 33.94	1
2	Assistant Director of Nursing	1,815	2,024	56,512	27.92	2
3	Registered Nurses	15,896	16,958	450,835	26.59	3
4	Licensed Practical Nurses	25,262	27,564	653,107	23.69	4
5	CNAs & Orderlies	94,731	101,849	1,240,799	12.18	5
6	CNA Trainees	1,300	1,300	15,663	12.05	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,018	3,691	82,968	22.48	8
9	Activity Director					9
10	Activity Assistants	6,623	7,142	86,913	12.17	10
11	Social Service Workers	1,958	2,032	33,878	16.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	50,369	53,058	538,606	10.15	15
16	Dishwashers					16
17	Maintenance Workers	5,485	6,606	91,865	13.91	17
18	Housekeepers	15,316	16,221	162,149	10.00	18
19	Laundry	6,002	6,691	72,745	10.87	19
20	Administrator	1,950	2,080	94,614	45.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,059	12,382	233,495	18.86	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)	243,637	261,631	\$ 3,883,148 *	\$ 14.84	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		2,400		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,800		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,168		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,368		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		
Janette Strabala			\$ 94,614	Workers' Compensation Insurance		\$ 77,971	IDPH License Fee		\$ 0		
				Unemployment Compensation Insurance		80,549	Advertising: Employee Recruitment		3,762		
				FICA Taxes		297,061	Health Care Worker Background Check				
				Employee Health Insurance		300,929	(Indicate # of checks performed _____)		4,775		
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		0			13,684		
				Other Benefits		35,573	Dues & Subscriptions		10,832		
				Central Office Allocation		51,957	License & Fees		5,101		
							Central Office Allocation		9,717		
							Less: Public Relations Expense		(13,684)		
							Non-allowable advertising		(1,179)		
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 844,040	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 33,008	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description		Amount		
			\$			\$	Out-of-State Travel		\$		
							In-State Travel				
									9,385		
									123		
							Seminar Expense		1,156		
									(8,665)		
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								(agree to Sch. V, line 24, col. 8)			
C. Professional Services								TOTAL			\$ 1,999
Vendor/Payee	Type		Amount								
Heritage Operations Group			\$ 376,582								
			0								
			0								
Legal adj to Zero			2,945								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL							

*** 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?yesIf 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?noIf 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.\$5,000Line10
- (7)Have all costs reported on this form been determined using accounting procedures consistent with prior reports?yesIf NO, attach a complete explanation.
- (8)Are you presently operating under a sale and leaseback arrangement?_____
If YES, give effective date of lease.
- (9)Are you presently operating under a sublease agreement?_____
YESxNO
- (10)Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES_____
NOxIf 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.\$71,370
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?noIf 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?yesFor 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.\$0Has any meal income been offset against related costs?yesIndicate the amount.\$246,774
- (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	3,203				1,009		1,009	PETTY CASH	3,203
1010	CASH IN BANK					1,100		1,100	ACCTS RECEIV-PRI	1,903,793
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCC	0
1100	ACCOUNTS RECEIVABLE	1,903,793				1,110		1,110	ACCTS RECEIV-M/C	0
1110	MEDICARE RECEIVABLES					1,125		1,125	ACCTS RECEIV-IPA	0
1125	IPA INCOME RECEIVABLE					1,135		1,135	ACCTS RECEIV-IC	0
1130	MEDICARE COST REPORT					1,140		1,140	UNAPPLIED CASH R	0
1135	ACCOUNTS RECEIVABLE-IC					1,145		1,145	A/R SUSPENSE-REF	0
1140	UNAPPLIED CASH RECEIPTS					1,200		1,200	PREPAID INSURAN	35,953
1145	A/R SUSPENSE-REFUNDS					1,220		1,220	OTHER PREPAID E	0
1190	ACCRUED INTEREST REC					1,300		1,300	DIETARY INVENTC	0
1200	PREPAID INSURANCE	35,953				1,310		1,310	SUPPLIES INVENTC	0
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY	0
1300	FOOD INVENTORY					1,409		1,409	LAND	0
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITURE & EQU	0
1409	LAND	0				1,460				0
1450	FURNITURE & EQUIPMENT	0				1,475		1,475	CODE ALERT MON	0
1460	ACCUM DEPR-FURN & EQU	0				1,490		1,490	ACCUM DEPR-BUI	0
1475	BUILDING & IMPROVEMEN	0				1,530		1,530	RESIDENT FUNDS	9,558
1490	ACCUM DEPR-BUILDING	0				1,550		1,550	LOAN FEES	0
1530	RESIDENT FUNDS	9,558				1,551		1,551	LOAN FEES ADDE	0
1550	LOAN FEES	0				1,850		1,850	INTERCOMPANY	(764,034)
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUNTS PAYAB	(339,899)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABL	0
1850	INTRACOMPANY	-764,034				2,100		2,100	ACCRUED PAYROL	(179,886)
2010	ACCOUNTS PAYABLE	-339,899				2,100		2,100	PR CLEARING-BEN	0
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-179,886				2,110		2,110	ACCRUED PTO PAY	(251,392)
2110	ACCRUED VACATION PAY	-251,392				2,120		2,120	U.C. TAXES PAYAB	0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAXES PAYABLE	(7,875)
2125	FICA TAX PAYABLE	-7,875	-7,875	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 REF	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETERIA	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUED INTEREST	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYMENTS PAID	(172,103)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL ESTATE TAX	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-172,103		2,400	2,400 CURRENT PORTION OF LT DEBT	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO RESIDENTS	(9,558)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE BANK #1	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEBT	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED EARNINGS	475,021
2460	INCOME TAXES PAYABLE				net income	(702,781)
2512	DUE TO RESIDENTS	-9,558				
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	475,021				
2970	PROFIT/LOSS FOR PERIOD	-702,781				
3007.1	PATIENT DAYS-PRIVATE	12,555				

3007.2	PATIENT DAYS-IPA	24,779				
3007.3	PATIENT DAYS-MEDICARE	7,342				
3007.4	PATIENT DAYS-CONVERSION					
3007.5	PATIENT DAYS-LICENSED					
3007.6	PATIENT DAYS-TOTAL					
3010	1 BASIC CHARGE-PRIVATE &	-7,961,872	0	0	0	0
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0
3020	1 BASIC CHARGE-IPA	0	0	0	0	0
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0
3035	4 DAY CARE/HOME CARE		0	0	0	0
3040	1 LIGHT NURSING CARE	0	0	0	0	0
3050	1 MEDIUM NURSING CARE		0	0	0	0
3060	1 HEAVY NURSING CARE		0	0	0	0
3061	1 SKILLED NURSING CARE					
3080	1 NURSING SUPPLIES-PRIVA	-115,790	0	0	0	0
3081	1 NURSING SUPPLIES-IPA		0	0	0	0
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0
3083	1 NURSING SUPPLIES MED PT B					
3100	17 DRUGS	-1,164,419	0	0	0	0
3101	17 DRUGS-OTHER					
3110	6 PT-PRIVATE	-2,260,081	0	0	0	0
3111	6 PT-IPA		0	0	0	0
3112	6 PT-MEDICARE PART A		0	0	0	0
3113	6 PT-MEDICARE PART B		0	0	0	0
3130	1 PUBLIC AID ASSESSMENT INC					
3140	19 LABORATORY INCOME		0	0	0	0
3150	6 SPEECH/OT-PRIVATE		0	0	0	0
3151	6 SPEECH/OT-IPA		0	0	0	0
3152	6 SPEECH/OT-MED PART A		0	0	0	0
3153	6 SPEECH/OT MED PART B					
3410	2 IPA DISCOUNTS	2,868,842	0	0	0	0
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0
3420	2 MEDICARE DISCOUNTS		0	0	0	0

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0
3520	16 RENT INCOME	0		6	0	6	0
3530	13 BEAUTY SHOP	-25,994		0	0	0	0
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0
3570	12 VENDING INCOME/EXPENSE	-1,131		0	0	0	0
3580	12 MANAGEMENT FEES			0	0	0	0
3590	1 EQUIPMENT RENTAL	-1,307		0	0	0	0
3595	21 RESIDENT TRANSPORTATION	-22,110		0	0	0	0
3600	21 MISC INCOME	0		0	0	0	0
4110	GENERAL & ADMINISTRATIVE WAGES	218,222	233,495	21	1	17	0
4111	ADMINISTRATOR WAGES	94,614	94,614	17	1	0	0
4115	VACATION & SICK - G&A	15,273		21	1	0	0
4120 4475	EMPLOYEE BENEFITS	26,113	792,083	22	3	0	0
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0
4130	EMPLOYEE SCHOLORSHIP	5,706		21	1	0	0
4135	EMPLOYEE SCHOLORSHIP	3,754		23	3	0	0
4220	DIRECTORS FEES	0	0	18	3	0	0
4250 4255	OFFICE SUPPLIES	29,697	29,697	21	2	0	0
4260	TELEPHONE	5,697	5,697	21	3	0	0
4275	TRAINING & EMPLOYEE DEVELOPMENT	8,710	8,710	23	3	16	-6,711 **
4280	GENERAL TRAVEL	9,385	10,664	24	3	16	0
4281	MEAL EXPENSE FOR TRAVEL	123		24	3	19	0
4285	EDUCATION & SEMINAR	1,156		24	3	19	-13,539 ***
4290	HELP WANTED ADVERTISING	3,762	119,910	20	3	0	0 -71,370
4291	PROMOTIONAL ADVERTISING	10,386		20	3	25	-10,386
4292	PUBLIC RELATIONS	13,684		20	3	25	-13,684
4300	LICENSES & FEES	76,471		20	3	17	0
4310	DUES & SUBSCRIPTIONS	10,832		20	3	17	-1,179
4320	CONTRIBUTIONS	3,988		27	3	20	0
4350	PROFESSIONAL FEES	2,945	379,527	19	3	22	-2,945
4355	MEDICAL DIRECTOR	2,400	2,400	9	3	0	0
4360	UTILIZATION REVIEW	0		10	3	0	0
4361	OTHER PHYSICIAN FEES			39	3	0	0

4362	MEDICAL RECORDS CONSULT	0		10	3	0	0
4363	PHARMACIST FEES	7,800		10	3	0	0
4364	SOC SERV/ACT CONSULT	3,168	3,168	12	3	0	0
4370	TV RENTAL	8,520		35	3	5	0
4380	INCOME TAXES		3,988	27	3	26	0
4383	BACKGROUND CHECKS	4,775		20	3	26	0
4400	PAYROLL TAXES	367,991		22	3	0	0
4401	PAYROLL TAXES ADMINIS	9,619		22	3	0	0
4410	GROUP INSURANCE	300,929		22	3	0	0
4420	LIABILITY INSURANCE	62,248	62,248	26	3	0	0
4425	INSURANCE-OWNERS			22	3	21	0
4430	WORKMENS COMP INSUR/	77,971		22	3	0	0
4450	CENTRAL OFFICE FEES	376,582		19	3	34	0 **
4460	BAD DEBTS	0		27	3	24	0
4470	LOST ITEMS-RESIDENTS	0		27	3	0	
4490	MISCELLANEOUS	0		27	3	0	0
4510	REAL ESTATE TAXES	0	0	33	3	0	0
4600	LEASED EQUIPMENT	7,596	16,116	35	3	16	0
5110	MAINTENANCE SALARIES	85,259	91,865	6	1	0	0
5120	MAINTENANCE SICK & VA	6,606		6	1	0	0
5130	ELECTRIC	70,414	141,389	5	3	0	0
5131	NATURAL GAS	32,238		5	3	0	0
5132	HEATING & DEISEL OIL			5	3	0	0
5133	WATER & SEWER	38,737		5	3	0	0
5134	TRASH COLLECTION	18,561	53,273	6	3	0	0
5140	PROPERTY PLANT REPLAC	42,096	88,869	6	2	0	0
5160	GENERAL REPAIR & MAIN'	46,773		6	2	0	0
5165	MAINTENANCE CONTRAC'	34,712		6	3	0	0
5210	DIETARY WAGES	520,496	538,606	1	1	0	0
5220	DIETARY SICK & VAC	18,110		1	1	0	0
5240	SALES TAX			2	3	13	0
5248	FOOD PURCHASES	337,476	90,702	2	2	0	0
5250	SUPPLIES-DISHWASHING	3,786	27,228	1	2	0	0

5260	DIETARY REPLACEMENT	9,243		1	2	0	0
5270	KITCHEN SUPPLIES-PAPER	14,199		1	2	0	0
5295	MEAL CREDIT	-246,774		2	2	0	0
5310	LAUNDRY WAGES	67,856	72,745	4	1	0	0
5340	LAUNDRY SICK & VAC	4,889		4	1	0	0
5370	LAUNDRY REPLACEMENT	18,845	26,656	4	2	0	0
5380	LAUNDRY REIMBURSEMENT			4	3	0	0
5390	LAUNDRY SUPPLIES	7,811		4	2	0	0
5410	HOUSEKEEPING WAGES	153,610	162,149	3	1	0	0
5440	HOUSEKEEPING SICK & VAC	8,539		3	1	0	0
5480	HOUSEKEEPING SUPPLIES	44,674	45,362	3	2	0	0
5490	HOUSEKEEPING SUPPLIES-	688		3	2	0	0
6010	RN WAGES-MEDICARE		2,553,220	10	1	0	0
6020	RN WAGES-NON MEDICAR	423,161		10	1	0	0
6030	DON WAGES	68,999		10	1	0	0
6035	ADON	56,512		10	1	0	0
6040	RN SICK & VACATION	27,674		10	1	0	0
6110	LPN WAGES-MEDICARE	616,587		10	1	0	0
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0
6130	LPN WAGES OTHER			10	1	0	0
6140	LPN SICK & VACATION	36,520		10	1	0	0
6210	AIDE WAGES-MEDICARE			10	1	0	0
6220	AIDE WAGES-NON MEDICAL	1,182,322		10	1	0	0
6230	WARD CLERKS			10	1	0	0
6240	AIDE VACATION & SICK	58,477		10	1	0	0
6245	CONTRACT NURSES-RN	0		10	3	0	0
6246	CONTRACT NURSES-LPN	0		10	3	0	0
6247	CONTRACT NURSES-AIDES	0		10	3	0	0
6250	NURSE AIDE TRAINING W/	15,663	15,663	13	1	0	0
6255	NURSE AID TRAINING EXP	600	600	13	2	0	0
6260	NURSE AIDE TRAINING RE	0		0	0	0	0
6270	REHAB WAGES	78,214		10	1	0	0
6275	REHAB SICK & VAC	4,754		10	1	0	0

6280	NURSING DEPT EDUCATION			23	3	0	0
6290	NURSING SUPPLIES	43,825	254,963	10	2	0	0
6295	NURSING SUPPLIES	199,740		10	2	0	0
6390	REPLACEMENT-NURSING	11,398		10	2	0	0
6490	NURSING OTHER	5,554	13,354	10	3	0	0
7280	DRUG PURCHASES	355,815	630,227	39	2	0	0 ***
7281	DRUG PURCHASES-OTHER	271,811		39	2		
7380	LABORATORY SERVICES	34,666	665,182	39	3	0	0
7410	HOME HEALTH SALARY			39	1	0	0
7440	HOME HEALTH SICK & VAC			39	1	0	0
7450	HOME HEALTH EXPENSES			39	3	0	0
7510	ACTIVITES WAGES	80,950	86,913	11	1	0	0
7540	ACTIVITIES SICK & VAC	5,963		11	1	0	0
7590	ACTIVITIES SUPPLIES	6,702	6,702	11	2	0	0
7595	ACTIVITIES FEES	0	0	11	3	0	0
7610	PT WAGES			39	1	0	0
7611	PT SICK & VACATION			39	1	0	0
7620	PT FEES	288,311		39	3	0	0 ***
7660	PT SUPPLIES	2,601		39	2	0	0
7710	SOCIAL SERVICE WAGES	31,968	33,878	12	1	0	0
7720	SOCIAL SERVICE SICK & V	1,910		12	1	0	0
7730	SOCIAL SERVICE EXPENSE	45	45	12	2	0	0
7740	OT FEE	306,389		39	3	0	0 ***
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0
7770	SPEECH THERAPY FEE	35,816		39	3	0	0 ***
7800	BEAUTICIAN WAGES		0	40	1	0	0
7810	BEAUTICIAN SICK & VAC			40	1	0	0
7820	BEAUTICIAN FEES	18,457	18,457	40	3	0	0
7890	BEAUTY SHOP SUPPLIES	1,185	1,185	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	569,400	569,400	34	3	0	0

8120	INTEREST EXPENSE	31,616	31,616	32	3	14	-1,485	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-1,485		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		7,981,081	7,982,566					
			1,485					

GRAND TOTALS

-702,781

-49,929

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	12,555	12,555
IPA	24,779	24,779
medicare	7,342	7,342
		44,676

IPA BEDHOLDS

0

PP BEDHOLDS

0

PP CONVERS

0

UND

RIA

3T

3T

3,007	3,007 PATIENT DA	24,779
3,007	3,007 PATIENT DA	7,342
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CHAI	(7,961,872)
3,020	3,020 BASIC CHAI	0
3,030	3,030 BASIC CHAI	0
3,040		0
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING SU	(115,790)
3,081	3,081 NURSING SU	0
3,082	3,082 NURSING SU	0
3,083	3,083 NURSING SU	0
3,100	3,100 DRUGS-MEI	(1,164,419)
3,101		0
3,110	3,110 PHYSICAL T	(2,260,081)
3,111		0
3,112	3,112 PHYSICAL T	0
3,113	3,113 PHYSICAL T	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT THER	0
3,153	3,153 ST/OT THER	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHER I	0
3,411	3,411 MEDICARE I	0
3,420	3,420 MEDICARE I	2,787,357
3,500		

3,520	3,520 RENT INCOM	0
3,530	3,530 BEAUTY SH	(25,994)
3,560		0
3,570	3,570 VENDING IN	(1,131)
3,590	3,590 EQUIPMENT	(1,307)
3,595	3,595 RESIDENT T	(22,110)
3,600	3,600 MISC INCOM	0
4,110	4,110 G&A WAGE	218,222
4,111	4,111 ADMINISTR	94,614
4,115	4,115 G&A PTO &	15,273
4,120	4,120 EMPLOYEE	23,313
4,125		0
4,130	4,130 EMPLOYEE	5,706
4,135	4,135 EMPLOYEE	3,754
4,250	4,250 OFFICE SUP	14,196
4,255	4,255 POSTAGE	3,392
4,260	4,260 TELEPHONE	5,697
4,275	4,275 TRAINING &	8,710
4,276		588
4,280	4,280 GENERAL T	9,385
4,281	4,281 MEAL EXPE	123
4,285	4,285 EDUCATION	1,010
4,289	4,289 MEETINGS I	146
4,290	4,290 HELP WANT	3,762
4,291	4,291 PROMOTION	10,386
4,292	4,292 PUBLIC REL	13,684
4,300	4,300 LICENSE & I	76,471
4,310	4,310 DUES & SUE	10,832
4,320	4,320 CONTRIBUT	3,988
4,350	4,350 PROFESSION	2,945
4,355	4,355 MEDICAL D	2,400
4,362		0
4,363		7,800

4,364	4,364 SOCIAL SER	3,168
4,370	4,370 TV RENTAL	8,520
4,383	4,383 BACKGROU	4,775
4,390	4,390 OTHER TAX	0
4,400	4,400 PAYROLL T.	367,991
4,401	4,401 PAYROLL T.	9,619
4,410	4,410 GROUP INSU	300,929
4,420	4,420 LIABILITY I	62,248
4,430	4,430 WORKMAN'	73,054
4,435	4,435 W/C-FIRST A	1,467
4,436	4,436 DRUG TESTI	2,862
4,450	4,450 MANAGEME	376,582
4,460	4,460 BAD DEBTS	0
4,461	4,461 BAD DEBTS	81,485
4,470	4,470 LOST ITEMS	0
4,475	4,475 UNIFORM E	2,800
4,486	4,486 SERVICE CC	20,211
4,490	4,490 MISC EXPEN	174
4,496	4,496 MISC. M.I.S.	12,109
4,510	4,510 REAL ESTAT	0
4,600	4,600 LEASED EQI	7,596
5,110	5,110 MAINTENAN	85,259
5,120	5,120 MAINTENAN	6,606
5,130	5,130 ELECTRIC	70,414
5,131	5,131 NATURAL G	32,238
5,133	5,133 WATER & SI	38,737
5,134	5,134 TRASH COL	18,561
5,140	5,140 PROP/PLAN	42,096
5,160	5,160 GENERAL R	46,773
5,165	5,165 MAINTENAN	14,501
5,210	5,210 DIETARY W	520,496
5,220	5,220 DIETARY PT	18,110
5,248	5,248 FOOD PURC	337,302

5,250	5,250 SUPPLIES DI	3,786
5,260	5,260 REPLACEMI	9,243
5,270	5,270 KITCHEN SU	14,199
5,295	5,295 MEAL INCO	(246,774)
5,310	5,310 LAUNDRY V	67,856
5,340	5,340 LAUNDRY P	4,889
5,370	5,370 REPLACEMI	18,845
5,380		0
5,390	5,390 SUPPLIES	7,811
5,410	5,410 HOUSEKEEP	153,610
5,440	5,440 HOUSEKEEP	8,539
5,480	5,480 SUPPLIES-Cl	44,674
5,490	5,490 SUPPLIES-H	688
6,020	6,020 RN WAGES	423,161
6,030	6,030 DON WAGES	68,999
6,035	6,035 ADON WAG	56,512
6,040	6,040 RN PTO & RI	27,674
6,120	6,120 LPN WAGES	616,587
6,140	6,140 LPN PTO & F	36,520
6,220	6,220 AIDES WAG	1,182,322
6,240	6,240 AIDES PTO &	58,477
6,245		
6,246		0
6,247		
6,250		15,663
6,255		600
6,260		0
6,270	6,270 REHAB WAC	78,214
6,275	6,275 REHAB PTO	4,754
6,290	6,290 NURSING SU	43,825
6,295	6,295 NURSING SU	199,740
6,390	6,390 REPLACEMI	11,398
6,490	6,490 OTHER	5,554

7,280	7,280 DRUG PURC	355,815
7,281	7,281 DRUG PURC	271,811
7,380	7,380 LABORATOI	3,154
7,391	7,390 X-RAY SERV	31,512
7,393		0
7,510	7,510 ACTIVITIES	80,950
7,540	7,540 ACTIVITIES	5,963
7,590	7,590 ACTIVITIES	6,702
7,620	7,620 PHYSICAL T	288,311
7,660	7,660 P.T. SUPPLY	2,601
7,710	7,710 SOCIAL SER	31,968
7,720	7,720 SOCIAL SER	1,910
7,730	7,730 SOCIAL SER	45
7,740	7,740 OCCUPATIO	306,389
7,750		0
7,770	7,770 SPEECH THI	35,816
7,820	7,820 BEAUTICIAI	18,457
7,890		1,185
7,960		0
8,120	8,120 INTEREST	0
8,125		31,616
8,130	8,130 DEPRECIAT	0
8,150		0
9,510	9,510 INTEREST IN	(1,485)
9,520	9,520 MISC NON-C	0
9,530	4,220	0
	8,100	569,400
	9,702	0
	5,230	0
		<u>(702,781)</u>

Expenses Fixed Assets

FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
Owned SNFs		
Heritage Health - South, IL	20-5300302001	48843
Heritage Health - Bloomington, IL	20-3904134001	48157
Heritage Health - Carlinville, IL	20-5508113001	48850
Heritage Health - Chillicothe, IL	20-5412664001	48868
Heritage Health - Dwight, IL	20-5412784001	50492
Heritage Health - Elgin, IL	20-3902154001	48132
Heritage Health - El Paso, IL	20-3903447001	48124
Heritage Health - Gibson City, IL	20-3902572001	48116
Heritage Health - Gillespie, IL	20-5428620001	48892
Heritage Health - LaSalle, IL	27-3741988001	51276
Heritage Health - Litchfield, IL	20-5508096001	48900
Heritage Health - Mendota, IL	20-3904038001	48108
Heritage Health - Minonka, IL	20-3903980001	48058
Heritage Health - Mt. Sterling, IL	20-3903543001	48041
Heritage Health - Mt. Zion, IL	20-3903622001	48074
Heritage Health - Normal, IL	20-3903883001	48082
Heritage Health - Pana, IL	20-5508128001	48884
Heritage Health - Peru, IL	20-3902978001	48090
Heritage Health - Staunton, IL	20-5437628001	48876
Heritage Health - Streator, IL	20-3902216001	48066
Barton W. Stone Jackson, IL	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health - Springfield, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Springfield, IL	37-6064916001	7880
Mason City Area, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth Lutheran, IL	37-0967671001	19976