

		FOR BHF USE			

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0048918</u></p> <p>Facility Name: <u>Heritage Health-Jacksonville</u></p> <p>Address: <u>873 Grove St</u> <u>Jacksonville</u> <u>62650</u> Number City Zip Code</p> <p>County: <u>Morgan</u></p> <p>Telephone Number: <u>(217)479-3400</u> Fax # <u>()</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/2007</u></p> <p>Type of Ownership:</p> <table border="0"><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input checked="" type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Craig Ater</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Exec VP & CFO</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td></td><td>(Telephone) _____</td><td>Fax # () _____</td></tr></table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Craig Ater</u>		Paid Preparer	(Title) <u>Exec VP & CFO</u>		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____			(Telephone) _____	Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																								
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	(Signed) _____	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) _____																																									
	(Telephone) _____	Fax # () _____																																								

Facility Name & ID Number Heritage Health-Jacksonville

0048918 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	185	Skilled (SNF)	185	67,710	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24	8,784	5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,494	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	26,506	24,902	6,515	57,923	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	465	3,186		3,651	12
13	DD 16 OR LESS					13
14	TOTALS	26,971	28,088	6,515	61,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.50%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/2007

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 6,515

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Heritage Health-Jacksonville

0048918

Report Period Beginning:

01/01/12

Ending:

12/31/12

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	530,302	21,087		551,389		551,389	11,465	562,854		1
2	Food Purchase		415,208		415,208		415,208	84	415,292		2
3	Housekeeping	266,999	42,974		309,973		309,973		309,973		3
4	Laundry	120,644	20,314		140,958		140,958		140,958		4
5	Heat and Other Utilities			208,631	208,631		208,631	2,734	211,365		5
6	Maintenance	136,835	158,088	94,010	388,933		388,933	28,229	417,162		6
7	Other (specify):*										7
8	TOTAL General Services	1,054,780	657,671	302,641	2,015,092		2,015,092	42,512	2,057,604		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	4,803	16,803		9
10	Nursing and Medical Records	3,570,212	268,846	17,305	3,856,363		3,856,363	2	3,856,365		10
10a	Therapy		701,432	970,520	1,671,952	(748,977)	922,975	219,524	1,142,499		10a
11	Activities	141,045	6,478		147,523		147,523		147,523		11
12	Social Services	78,849	780	5,287	84,916		84,916		84,916		12
13	CNA Training	4,571	871		5,442		5,442	1,914	7,356		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,794,677	978,407	1,005,112	5,778,196	(748,977)	5,029,219	226,243	5,255,462		16
	C. General Administration										
17	Administrative	94,622			94,622		94,622		94,622		17
18	Directors Fees										18
19	Professional Services			482,579	482,579		482,579	(452,211)	30,368		19
20	Dues, Fees, Subscriptions & Promotions			158,417	158,417	(60,939)	97,478	(12,548)	84,930		20
21	Clerical & General Office Expenses	350,750	34,904	25,527	411,181		411,181	520,798	931,979		21
22	Employee Benefits & Payroll Taxes			1,185,814	1,185,814		1,185,814	73,938	1,259,752		22
23	Inservice Training & Education			9,428	9,428		9,428	(7,429)	1,999		23
24	Travel and Seminar			5,745	5,745		5,745	(3,746)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			102,788	102,788		102,788	20,155	122,943		26
27	Other (specify):*			4,487	4,487		4,487	(3,000)	1,487		27
28	TOTAL General Administration	445,372	34,904	1,974,785	2,455,061	(60,939)	2,394,122	135,957	2,530,079		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,294,829	1,670,982	3,282,538	10,248,349	(809,916)	9,438,433	404,712	9,843,145		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							354,075	354,075			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,955	44,955		44,955	160,134	205,089			32
33	Real Estate Taxes							90,600	90,600			33
34	Rent-Facility & Grounds			1,038,060	1,038,060		1,038,060	(1,026,355)	11,705			34
35	Rent-Equipment & Vehicles			13,958	13,958		13,958	1,806	15,764			35
36	Other (specify):*											36
37	TOTAL Ownership			1,096,973	1,096,973		1,096,973	(419,740)	677,233			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					748,977	748,977		748,977			39
40	Barber and Beauty Shops		1,061	39,774	40,835		40,835		40,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,939	60,939		60,939			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,061	39,774	40,835	809,916	850,751		850,751			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,294,829	1,672,043	4,419,285	11,386,157		11,386,157	(15,028)	11,371,129			45

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

Facility Name & ID Number Heritage Health-Jacksonville

0048918

Report Period Beginning: 01/01/12

Ending: 12/31/12

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	(6,396)			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)	(7,429)			16
17	Non-Care Related Fees	(1,303)			17
18	Fines and Penalties				18
19	Entertainment	(10,681)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,569)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,000)			24
25	Fund Raising, Advertising and Promotional	(25,073)			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)	\$ (69,451)		\$	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)	54,423		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 54,423		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (15,028)		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-Jacksonville

Report Period Beginning: 01/01/12
 Ending: 12/31/12

ID# 0048918

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

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	(1,303)	20	17
18			18
19		24	19
20	0	27	20
21			21
22	(15,569)	19	22
23			23
24	(3,000)	27	24
25	(25,073)	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		(44,945)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Jacksonville# 0048918

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	11,465	0	0	0	0	0	0	0	0	11,465	1
2	Food Purchase	0	0	84	0	0	0	0	0	0	0	0	84	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	2,734	0	0	0	0	0	0	0	0	2,734	5
6	Maintenance	0	0	28,229	0	0	0	0	0	0	0	0	28,229	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	42,512	0	0	0	0	0	0	0	0	42,512	8
	B. Health Care and Programs													
9	Medical Director	0	0	4,803	0	0	0	0	0	0	0	0	4,803	9
10	Nursing and Medical Records	0	0	2	0	0	0	0	0	0	0	0	2	10
10a	Therapy	0	219,524	0	0	0	0	0	0	0	0	0	219,524	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	1,914	0	0	0	0	0	0	0	0	1,914	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	219,524	6,719	0	0	0	0	0	0	0	0	226,243	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	(15,569)	(467,010)	30,368	0	0	0	0	0	0	0	0	(452,211)	19
20	Fees, Subscriptions & Promotions	(26,376)	0	13,828	0	0	0	0	0	0	0	0	(12,548)	20
21	Clerical & General Office Expenses	0	0	520,798	0	0	0	0	0	0	0	0	520,798	21
22	Employee Benefits & Payroll Taxes	0	0	73,938	0	0	0	0	0	0	0	0	73,938	22
23	Inservice Training & Education	(7,429)	0	0	0	0	0	0	0	0	0	0	(7,429)	23
24	Travel and Seminar	(10,681)	0	6,935	0	0	0	0	0	0	0	0	(3,746)	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	20,155	0	0	0	0	0	0	0	0	20,155	26
27	Other (specify):*	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	27
28	TOTAL General Administration	(63,055)	(467,010)	666,022	0	0	0	0	0	0	0	0	135,957	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,055)	(247,486)	715,253	0	0	0	0	0	0	0	0	404,712	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Jacksonville# 0048918

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	322,780	0	31,295	0	0	0	0	0	0	0	354,075	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,396)	165,810	0	720	0	0	0	0	0	0	0	160,134	32
33	Real Estate Taxes	0	90,521	0	79	0	0	0	0	0	0	0	90,600	33
34	Rent-Facility & Grounds	0	(1,038,060)	0	11,705	0	0	0	0	0	0	0	(1,026,355)	34
35	Rent-Equipment & Vehicles	0	0	0	1,806	0	0	0	0	0	0	0	1,806	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,396)	(458,949)	0	45,605	0	0	0	0	0	0	0	(419,740)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(69,451)	(706,435)	715,253	45,605	0	0	0	0	0	0	0	(15,028)	45

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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>See Pg 25</u>				

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)	
	V		\$			\$		1
	V	<u>10a Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>219,524</u>	<u>219,524</u>	2
	V							3
	V	<u>19 Adjustment for Related Organization</u>	<u>467,010</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(467,010)</u>	4
	V							5
	V	<u>34 Adjustment for Related Organization</u>	<u>1,038,060</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(1,038,060)</u>	6
	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>90,521</u>	<u>90,521</u>	7
	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>161,037</u>	<u>161,037</u>	8
	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>322,780</u>	<u>322,780</u>	9
	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
	V							11
	V							12
	V							13
	Total		\$ 1,505,070			\$ 798,635	\$ * (706,435)	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.		\$	\$ 11,465	15
16	V	2 Food Purchase					84	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					2,734	19
20	V	6 Maintenance					28,229	20
21	V	7 Other					0	21
22	V	9 Medical Director					4,803	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					1,914	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					30,368	31
32	V	20 Fees, Subscription, Promotions					13,828	32
33	V	21 Clerical & General Office Expenses					520,798	33
34	V	22 Employee Benefits & Payroll Taxes					73,938	34
35	V	23 Inservice Training & Education					0	35
36	V	24 Travel and Seminar					6,935	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					20,155	38
39	Total		\$			\$	0	\$ * 715,253 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						31,295	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						720	18	
19	V	33 Real Estate Taxes						79	19	
20	V	34 Rent-Facility & Grounds						11,705	20	
21	V	35 Rent-Equipment & Vehicles						1,806	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	\$ *	45,605	39

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

Facility Name & ID Number

Heritage Health-Jacksonville

0048918

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

Facility Name & ID Number Heritage Health-Jacksonville # 0048918 Report Period Beginning: 01/01/12 Ending: 12/31/12

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-Jacksonville

0048918

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

Name of Related Organization Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

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

1	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	185	\$ 11,465	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	185	84	2
3	3	Housekeeping	Beds	2,735	26	0	0	185	0	3
4	4	Laundry	Beds	2,735	26	0	0	185	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	185	2,734	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	185	28,229	6
7	7	Other	Beds	2,735	26	0	0	185	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	185	4,803	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	185	2	9
10	11	Activities	Beds	2,735	26	0	0	185	0	10
11	12	Social Service	Beds	2,735	26	0	0	185	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	185	1,914	12
13	14	Program Transportation	Beds	2,735	26	0	0	185	0	13
14	15	Other	Beds	2,735	26	0	0	185	0	14
15	17	Administrative	Beds	2,735	26	0	0	185	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	185	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	185	30,368	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	185	13,828	18
19	21	Clerical & General Office Expens	Beds	2,735	26	7,699,360	7,229,609	185	520,798	19
20	22	Employee Benefits & Payroll Tax	Beds	2,735	26	1,093,087	0	185	73,938	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	185	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	185	6,935	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	185	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	297,962	0	185	20,155	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 715,253	25

Facility Name & ID Number Heritage Health-Jacksonville

0048918

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

Name of Related Organization Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

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

1	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	\$	\$	185	\$	1
2	30	Depreciation	Beds	2,735	26	462,659	185	31,295		2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26		185			3
4	32	Interest	Beds	2,735	26	10,650	185	720		4
5	33	Real Estate Taxes	Beds	2,735	26	1,164	185	79		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045	185	11,705		6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702	185	1,806		7
8	36	Other	Beds	2,735	26		185			8
9	38	Medically Nec Transportation	Beds	2,735	26		185			9
10	39	Ancillary Service Centers	Beds	2,735	26		185			10
11	40	Barber and Beauty Shops	Beds	2,735	26		185			11
12	41	Coffee and Gift Shops	Beds	2,735	26		185			12
13	42	Other	Beds	2,735	26		185			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	\$		\$ 45,605	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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			\$	\$ 2,999,146			\$ 161,037	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							44,955	6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$ 2,999,146			\$ 210,765	9				
B. Non-Facility Related*																
10	Interest Income										(6,396)	10				
11												11				
12	Allocated Corporate										720	12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (5,676)	14				
15	TOTALS (line 9+line14)						\$	\$ 2,999,146			\$ 205,089	15				

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	90,521		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	90,521		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.		\$	90,521		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	_____	8	FOR BHF USE ONLY		
	2008	_____	9			
	2009	_____	10			
	2010	_____	11			
	2011	90,521	12			
				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-Jacksonville COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0048918

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>0920308003</u>	_____	\$ <u>119,107.00</u>	\$ <u>90,521.00</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>119,107.00</u></u>	\$ <u><u>90,521.00</u></u>

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.**

Facility Name & ID Number Heritage Health-Jacksonville

0048918 Report Period Beginning:

01/01/12 Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>100,000</u>	1
2					2
3	TOTALS			\$ <u>100,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	209			\$ 3,295,725	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Facility Sign		2005	1,050					
10	Dietary cabinets		2005	5,864					
11	Ansul system		2005	1,600					
12	Heat detectors		2005	1,777					
13	Door system		2005	17,554					
14	A/C units		2005	10,456					
15									
16	Computer wiring		2005	1,280					
17	A/C compressor		2005	2,849					
18	Shelter care remodel-- paint, flooring, wallpaper		2006	225,040					
19	landscapping		2006	2,262					
20	Boiler		2006	2,580					
21	Heat/cool units		2006	9,517					
22	Fire alarm		2006	2,097					
23	Roof		2006	145,352					
24	Door system		2006	414					
25	Mixing Valve		2006	5,060					
26	Hutton Hall remodel (Shelter Care) -- Window treatments, painting		2006	31,147					
27	sump pump		2006	2,001					
28	2006 audit adjustment		2006	(78,685)					
29									
30									
31									
32									
33	C/O Allocation				31,295			(31,295)	
34	Book Depreciation				238,168		238,168		
35									
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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Backflow preventer	2007	\$ 3,501	\$		\$	\$	\$	37
38	Shower/faucet	2007	875						38
39	Air Handler	2007	5,215						39
40	HVAC	2007	20,152						40
41	Tree removal	2007	9,491						41
42	Valance	2007	581						42
43	Younkin corridor remodel -- paint	2007	16,420						43
44	Trane compressor	2007	2,841						44
45	Elevator	2007	68,750						45
46	Parking lot	2007	10,570						46
47	Aufit Adjustment	2007	(38,621)						47
48									48
49									49
50									50
51									51
52	Nurse Call System	2008	286,152						52
53	Mechanical systems	2008	12,996						53
54	Condensing Unit	2008	17,965						54
55	Laundry plumbing	2008	12,671						55
56	Heat / Cool units	2008	24,201						56
57	Fire Panel	2008	7,378						57
58	Water Heater	2008	5,272						58
59	Kitchen Air Handler	2008	26,187						59
60	Condensing Unit	2008	4,069						60
61	Wireless Phone system	2008	41,983						61
62	Cables-nurse call	2008	21,185						62
63	Resident Phones	2008	10,081						63
64	Audit Adjustment	2008	2,254						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,257,109	\$ 269,463		\$ 238,168	\$ (31,295)	\$	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,257,109	\$ 269,463		\$ 238,168	\$ (31,295)	\$	1
2	Compressor	2009	2,516						2
3	Condensing Unit	2009	16,946						3
4	Boiler Replacement	2009	10,434						4
5	Roof	2009	8,393						5
6	HVAC units	2009	5,735						6
7	Firewall	2009	6,951						7
8	HVAC units	2009	5,106						8
9	Laundry plumbing	2009	7,351						9
10	Sewer ejector	2009	5,189						10
11	Dinning room paint, flooring & labor	2009	55,148						11
12	Cabling	2009	10,874						12
13	Laundry plumbing	2009	7,015						13
14									14
15	Roof Repair	2010	10,654						15
16	heat/cool units	2010	11,449						16
17	Driveway sealant	2010	3,800						17
18	Wanderguard	2010	3,099						18
19	Furnace	2010	4,095						19
20	Carpet	2010	3,523						20
21	Dinning room paint, flooring & labor	2010	53,752						21
22	Boiler Replacement	2010	25,619						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)		\$ 4,514,758	\$ 269,463		\$ 238,168	\$ (31,295)	\$	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,514,758	\$ 269,463		\$ 238,168	\$ (31,295)	\$	1
2									2
3	Islandaire stystem	2011	8,122						3
4	PTAC units	2011	21,011						4
5	44 windows	2011	73,900						5
6	roof	2011	8,393						6
7	boiler	2011	19,466						7
8	sign	2011	12,169						8
9	Technology system	2011	22,503						9
10	walk-in cooler	2011	9,893						10
11	furnace	2011	7,952						11
12	Sprinkler system	2011	27,872						12
13									13
14	Technology system	2012	6,347						14
15	Physical Therapy room rehab : Paint, floors labor	2012	164,844						15
16	Boiler	2012	4,397						16
17	Compressor	2012	3,299						17
18	Nurse Call System	2012	15,854						18
19	Condensing Unit	2012	8,079						19
20	Flooring	2012	3,818						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)		\$ 4,932,677	\$ 269,463		\$ 238,168	\$ (31,295)	\$	34

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

Facility Name & ID Number Heritage Health-Jacksonville

0048918

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 4,932,677	\$ 269,463		\$ 238,168	\$ (31,295)	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 4,932,677	\$ 269,463		\$ 238,168	\$ (31,295)	\$

**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	\$ 1,211,483	\$ 84,612	\$ 84,612	\$		\$	71
72	Current Year Purchases	33,025						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,244,508	\$ 84,612	\$ 84,612	\$		\$	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)	\$ 6,277,185	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 354,075	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,780	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,295)	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: \$ 13,958 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.

Facility Name & ID Number Heritage Health-Jacksonville # 0048918 Report Period Beginning: 01/01/12 Ending: 12/31/12
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		871		871
3	Classroom Wages (a)				
4	Clinical Wages (b)		4,571		4,571
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,442	\$	\$ 5,442
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,442		

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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 387,977	\$		\$ 387,977	1
2	Licensed Speech and Language Development Therapist		hrs				127,768			127,768	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				407,148	82		407,230	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					701,350		701,350	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						47,627			47,627	13
14	TOTAL			\$			\$ 970,520	\$ 701,432		\$ 1,671,952	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.

Facility Name & ID Number Heritage Health-Jacksonville

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (last day of reporting year)

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	\$ 6,205	\$	1
2	Cash-Patient Deposits	33,712		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,815,987		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,369		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,661,476)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (794,203)	\$	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)	\$ (794,203)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 317,224	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,712		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	563,149		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,134		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,340		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>	231,649		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,161,208	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	106,550		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)	\$ 106,550	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,267,758	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,061,961)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (794,203)	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,787,053)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,787,053)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(274,908)	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)	\$ (274,908)	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)	\$ (2,061,961)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,787,194	1
2	Discounts and Allowances for all Levels	(3,523,085)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,264,109	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,244,425	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,244,425	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	3,953	12
13	Barber and Beauty Care	49,498	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,333,011	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	49,522	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,435,984	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,396	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,396	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		160,335	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 160,335	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,111,249	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,015,092	31
32	Health Care	5,778,196	32
33	General Administration	2,455,061	33
B. Capital Expense			
34	Ownership	1,096,973	34
C. Ancillary Expense			
35	Special Cost Centers	40,835	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)*	\$ 11,386,157	40
41	Income before Income Taxes (line 30 minus line 40)**	(274,908)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (274,908)	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.

Facility Name & ID Number Heritage Health-Jacksonville

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Report Period Beginning:

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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	1,864	2,024	\$ 66,880	\$ 33.04	1
2	Assistant Director of Nursing	1,842	2,024	52,582	25.98	2
3	Registered Nurses	15,411	16,395	420,430	25.64	3
4	Licensed Practical Nurses	41,439	46,919	980,951	20.91	4
5	CNAs & Orderlies	149,166	161,554	1,979,615	12.25	5
6	CNA Trainees			4,571		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,561	4,069	69,754	17.14	8
9	Activity Director					9
10	Activity Assistants	10,568	11,572	141,045	12.19	10
11	Social Service Workers	3,809	4,102	78,849	19.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,002	45,638	530,302	11.62	15
16	Dishwashers					16
17	Maintenance Workers	9,015	9,839	136,835	13.91	17
18	Housekeepers	23,029	25,399	266,999	10.51	18
19	Laundry	11,225	12,173	120,644	9.91	19
20	Administrator	1,900	2,080	94,622	45.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,531	17,010	350,750	20.62	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)	330,362	360,798	\$ 5,294,829 *	\$ 14.68	34

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

** See instructions.

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	12,000		36
37	Medical Records Consultant	1,560		37
38	Nurse Consultant			38
39	Pharmacist Consultant	12,540		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	5,287		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 31,387		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

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	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Jacksonville# 0048918

Report Period Beginning:

01/01/12

Ending:

12/31/12**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. \$ 60,939
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. \$ 12,095
- (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 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 Adjustment Line #	Amount
1009	PETTY CASH	6,205				1,009	1,009 PETTY C 6,205
1010	CASH IN BANK					1,100	1,100 ACCTS R 1,815,987
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	1,815,987				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 11,369
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	11,369				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 0
1409	LAND	0				1,460	0
1450	FURNITURE & EQUIPMENT	0				1,475	1,475 CODE AI 0
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM] 0
1475	BUILDING & IMPROVEMEN	0				1,530	1,530 RESIDEN 33,712
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	33,712				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (2,661,476)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (317,224)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-2,661,476				2,100	2,100 ACCRUE (240,328)
2010	ACCOUNTS PAYABLE	-317,224				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-240,328				2,110	2,110 ACCRUE (322,821)
2110	ACCRUED VACATION PAY	-322,821				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(7,134)	
2125	FICA TAX PAYABLE	-7,134	-7,134	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(231,649)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	(8,340)	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-231,649		2,400	2,400 CURRENT PORTION OF LT DE		
2350	REAL ESTATE TAX PAYAB	-8,340		2,512	2,512 DUE TO I	(33,712)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(106,550)	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DE		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	1,787,053	
2460	INCOME TAXES PAYABLE					net income	274,908
2512	DUE TO RESIDENTS	-33,712					
2600	MORTGAGE PAYABLE	-106,550					
2650	EQUIPMENT LOAN PAYABLE					balance	<u>0</u>
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	1,787,053					
2970	PROFIT/LOSS FOR PERIOD	274,908					
3007.1	PATIENT DAYS-PRIVATE	24,902					3,007

3007.2	PATIENT DAYS-IPA	26,506						3,007
3007.3	PATIENT DAYS-MEDICARE	6,515						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 &	-9,686,596	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	-88,272	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	-1,333,011	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-3,244,425	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	3,523,085	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	-49,498		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-1,971		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-1,982		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-12,326		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-49,310		0	0	0	0		4,110
3600	21 MISC INCOME	-212		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	330,366	350,750	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	94,622	94,622	17	1	0	0		4,120
4115	VACATION & SICK - G&A	20,384		21	1	0	0		4,125
4120 4475	EMPLOYEE BENEFITS	21,751	1,185,814	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP	4,129		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP	695		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	34,904	34,904	21	2	0	0		4,275
4260	TELEPHONE	25,527	25,527	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	9,428	9,428	23	3	16	-7,429 **		4,280
4280	GENERAL TRAVEL	4,828	5,745	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	12		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	905		24	3	19	-10,681 ***		4,289
4290	HELP WANTED ADVERTISING	9,400	158,417	20	3	0	0	-60,939	4,290
4291	PROMOTIONAL ADVERTISING	15,968		20	3	25	-15,968		4,291
4292	PUBLIC RELATIONS	9,105		20	3	25	-9,105		4,292
4300	LICENSES & FEES	105,648		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	15,983		20	3	17	-1,303		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	15,569	482,579	19	3	22	-15,569		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	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 CONSI	1,560		10	3	0	0	4,364
4363	PHARMACIST FEES	12,540		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	5,287	5,287	12	3	0	0	4,383
4370	TV RENTAL	7,437		35	3	5	0	4,390
4380	INCOME TAXES		4,487	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,313		20	3	26	0	4,401
4400	PAYROLL TAXES	503,581		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	9,609		22	3	0	0	4,420
4410	GROUP INSURANCE	526,547		22	3	0	0	4,430
4420	LIABILITY INSURANCE	102,788	102,788	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	119,502		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	467,010		19	3	34	0 **	4,460
4460	BAD DEBTS	3,000		27	3	24	-3,000	4,461
4470	LOST ITEMS-RESIDENTS	1,487		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	6,521	13,958	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	127,999	136,835	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	8,836		6	1	0	0	4,510
5130	ELECTRIC	136,917	208,631	5	3	0	0	4,600
5131	NATURAL GAS	37,775		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	33,939		5	3	0	0	5,130
5134	TRASH COLLECTION	31,176	94,010	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	57,117	158,088	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	100,971		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	62,834		6	3	0	0	5,140
5210	DIETARY WAGES	498,804	530,302	1	1	0	0	5,160
5220	DIETARY SICK & VAC	31,498		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	427,303	415,208	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	7,317	21,087	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	2,866		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	10,904		1	2	0	0	5,260
5295	MEAL CREDIT	-12,095		2	2	0	0	5,270
5310	LAUNDRY WAGES	112,799	120,644	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	7,845		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	7,933	20,314	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	12,381		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	255,092	266,999	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	11,907		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	11,691	42,974	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	31,283		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		3,570,212	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	397,512		10	1	0	0	6,020
6030	DON WAGES	66,880		10	1	0	0	6,030
6035	ADON	52,582		10	1	0	0	6,035
6040	RN SICK & VACATION	22,918		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	930,978		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	49,973		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	1,897,678		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	81,937		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 WA	4,571	4,571	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	871	871	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	66,383		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,371		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	218,641	268,846	10	2	0	0	7,281
6295	NURSING SUPPLIES	50,205		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	0		10	2	0	0	7,391
6490	NURSING OTHER	3,205	17,305	10	3	0	0	7,393
7280	DRUG PURCHASES	276,403	701,432	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	424,947		39	2			7,540
7380	LABORATORY SERVICES	47,627	970,520	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	132,750	141,045	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	8,295		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	6,478	6,478	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	407,148		39	3	0	0 ***	7,890
7660	PT SUPPLIES	82		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	73,941	78,849	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	4,908		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	780	780	12	2	0	0	8,130
7740	OT FEE	387,977		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	127,768		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	39,774	39,774	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	1,061	1,061	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	1,038,060	1,038,060	34	3	0	0	

8120	INTEREST EXPENSE	44,955	44,955	32	3	14	-6,396	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-6,396		32	0	10	0	
9520	MISC NON-OPERATING INC	-160,335		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

11,219,426 11,386,157
166,731

GRAND TOTALS

274,908 -69,451
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

G/L

RECAP CENSUS

PP 24,902
IPA 26,506
medicare 6,515

24,902
26,506
6,515
57,923

IPA BEDHOLDS 0
PP BEDHOLDS 0
PP CONVERS 0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 24,902

HFS 3745 (N-4-99)

IL478-2471

3,007 PATIENT	26,506
3,007 PATIENT	6,515
	0

3,010 BASIC CI (9,686,596)

3,020 BASIC CI 0

3,030 BASIC CI 0

0

0

0

0

3,080 NURSING (88,272)

3,081 NURSING 0

3,082 NURSING 0

3,083 NURSING 0

3,100 DRUGS-M (1,333,011)

0

3,110 PHYSICIAN (3,244,425)

0

3,112 PHYSICIAN 0

3,113 PHYSICIAN 0

3,140 LABORATORY INCOME

0

3,152 ST/OT TR 0

3,153 ST/OT TR 0

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER 0

3,411 MEDICAL 0

3,420 MEDICAL 3,390,622

3,520 RENT INC	0
3,530 BEAUTY	(49,498)
	(1,971)
3,570 VENDING	(1,982)
3,590 EQUIPMI	(12,326)
3,595 RESIDEN	(49,310)
3,600 MISC INC	(212)
4,110 G&A WA	330,366
4,111 ADMINIS	94,622
4,115 G&A PTC	20,384
4,120 EMPLOY	24,457
	0
4,130 EMPLOY	4,129
4,135 EMPLOY	695
4,250 OFFICE S	24,014
4,255 POSTAGI	3,291
4,260 TELEPHC	25,527
4,275 TRAININ	9,428
	(180)
4,280 GENERA	4,828
4,281 MEAL EX	12
4,285 EDUCAT	905
4,289 MEETING	0
4,290 HELP WA	9,400
4,291 PROMOT	15,968
4,292 PUBLIC I	9,105
4,300 LICENSE	105,648
4,310 DUES & :	15,983
4,320 CONTRIE	0
4,350 PROFESS	15,569
4,355 MEDICAL	12,000
	1,560
	12,540

4,364 SOCIAL S	5,287
4,370 TV RENT	7,437
4,383 BACKGR	2,313
4,390 OTHER T	0
4,400 PAYROL	503,581
4,401 PAYROL	9,609
4,410 GROUP I	526,547
4,420 LIABILIT	102,788
4,430 WORKM	115,798
4,435 W/C-FIRS	784
4,436 DRUG TE	3,100
4,450 MANAGI	467,010
4,460 BAD DEF	3,000
4,461 BAD DEF	132,463
4,470 LOST ITE	1,487
4,475 UNIFORM	(2,706)
4,486 SERVICE	35,402
4,490 MISC EX	400
4,496 MISC. M.	7,599
4,510 REAL ES	0
4,600 LEASED	6,521
5,110 MAINTEI	127,999
5,120 MAINTEI	8,836
5,130 ELECTRI	136,917
5,131 NATURA	37,775
5,133 WATER &	33,939
5,134 TRASH C	31,176
5,140 PROP/PL	57,117
5,160 GENERA	100,971
5,165 MAINTEI	27,432
5,210 DIETARY	498,804
5,220 DIETARY	31,498
5,248 FOOD PU	426,903

5,250 SUPPLIE	7,317
5,260 REPLACI	2,866
5,270 KITCHEN	10,904
5,295 MEAL IN	(12,095)
5,310 LAUNDR	112,799
5,340 LAUNDR	7,845
5,370 REPLACI	7,933
	0
5,390 SUPPLIE	12,381
5,410 HOUSEK	255,092
5,440 HOUSEK	11,907
5,480 SUPPLIE	11,691
5,490 SUPPLIE	31,283
6,020 RN WAG	397,512
6,030 DON WA	66,880
6,035 ADON W	52,582
6,040 RN PTO	22,918
6,120 LPN WAG	930,978
6,140 LPN PTO	49,973
6,220 AIDES W	1,897,678
6,240 AIDES PT	81,937
	0
	0
	0
	4,571
	871
	0
6,270 REHAB V	66,383
6,275 REHAB F	3,371
6,290 NURSINC	218,641
6,295 NURSINC	50,205
6,390 REPLACI	0
6,490 OTHER	3,205

7,280 DRUG PU	276,403
7,281 DRUG PU	424,947
7,380 LABORA	9,613
7,390 X-RAY S	1,675
	36,339
7,510 ACTIVIT	132,750
7,540 ACTIVIT	8,295
7,590 ACTIVIT	6,478
7,620 PHYSICA	407,148
7,660 P.T. SUPE	82
7,710 SOCIAL S	73,941
7,720 SOCIAL S	4,908
7,730 SOCIAL S	780
7,740 OCCUPA	387,977
	0
7,770 SPEECH'	127,768
7,820 BEAUTIC	39,774
	1,061
	0
8,120 INTERES	0
	44,955
8,130 DEPRECI	0
	0
9,510 INTERES	(6,396)
9,520 MISC NO	0
4,220	0
8,100	1,038,060
9,702	(160,335)
5,230	0
	<u>274,908</u>

Expenses Fixed Assets

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