FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0051276

Facility Name: Heritage Health-LaSalle

Address: 1445 Chartres Street (Number) LaSalle (City) 61301 (Zip Code)

County: LaSalle

Telephone Number: (815)223-4700 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: Jan 2011

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dave Underwood **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 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) David M. Underwood
(Title) Sr. VP & CFO

Paid Preparer

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

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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	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	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,955	4,137	1,999	30,091	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,955	4,137	1,999	30,091	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.62%

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? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started Jan 2011

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,999

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	192,113	7,987		200,100		200,100	7,118	207,218			1
2	Food Purchase		168,815		168,815		168,815	31	168,846			2
3	Housekeeping	60,656	23,568		84,224		84,224	4	84,228			3
4	Laundry	54,692	14,530		69,222		69,222		69,222			4
5	Heat and Other Utilities			94,243	94,243		94,243	1,562	95,805			5
6	Maintenance	77,939	22,425	61,190	161,554		161,554	15,451	177,005			6
7	Other (specify):*											7
8	TOTAL General Services	385,400	237,325	155,433	778,158		778,158	24,166	802,324			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,535,120	76,083	13,169	1,624,372		1,624,372	2,758	1,627,130			10
10a	Therapy		255,644	274,903	530,547	(261,636)	268,911		268,911			10a
11	Activities	84,276	1,665		85,941		85,941		85,941			11
12	Social Services	23,706		2,677	26,383		26,383		26,383			12
13	CNA Training							596	596			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,643,102	333,392	314,749	2,291,243	(261,636)	2,029,607	3,354	2,032,961			16
	C. General Administration											
17	Administrative	83,056			83,056		83,056		83,056			17
18	Directors Fees											18
19	Professional Services			187,609	187,609		187,609	(167,771)	19,838			19
20	Dues, Fees, Subscriptions & Promotions			91,962	91,962	(55,298)	36,664	(12,638)	24,026			20
21	Clerical & General Office Expenses	159,321	19,478	10,471	189,270		189,270	295,275	484,545			21
22	Employee Benefits & Payroll Taxes			447,810	447,810		447,810	44,802	492,612			22
23	Inservice Training & Education			4,954	4,954		4,954	599	5,553			23
24	Travel and Seminar			2,172	2,172		2,172	(173)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			39,971	39,971		39,971	11,189	51,160			26
27	Other (specify):*											27
28	TOTAL General Administration	242,377	19,478	784,949	1,046,804	(55,298)	991,506	171,283	1,162,789			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,270,879	590,195	1,255,131	4,116,205	(316,934)	3,799,271	198,803	3,998,074			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.

Facility Name & ID Number Heritage Health-LaSalle #0051276 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			19,571	19,571		19,571	18,950	38,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,311	21,311		21,311	(26,173)	(4,862)			32
33	Real Estate Taxes			69,381	69,381		69,381		69,381			33
34	Rent-Facility & Grounds			353,172	353,172		353,172	6,682	359,854			34
35	Rent-Equipment & Vehicles			8,681	8,681		8,681	4,754	13,435			35
36	Other (specify):*											36
37	**TOTAL Ownership**			472,116	472,116		472,116	4,213	476,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					261,636	261,636	11,557	273,193			39
40	Barber and Beauty Shops			(3,236)	(3,236)		(3,236)		(3,236)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,298	55,298		55,298			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			(3,236)	(3,236)	316,934	313,698	11,557	325,255			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,270,879	590,195	1,724,011	4,585,085		4,585,085	214,573	4,799,658			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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(26,603)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,115)			17
18	Fines and Penalties				18
19	Entertainment	(7,254)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,494)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,902)			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)**	$ (58,368)		$	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 Amount	2 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)	272,941		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 272,941		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 214,573		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS **Page 5A**

Heritage Health-LaSalle

ID# **0051276**

Report Period Beginning: **01/01/13**

Ending: **12/31/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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		0	33	15
16			24	16
17		(1,115)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,494)	19	22
23				23
24		0	27	24
25		(21,902)	20	25
26				26
27				27
28				28
29				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**	(24,511)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-LaSalle **#** 0051276 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	7,118	0	0	0	0	0	0	0	0	7,118	1
2	Food Purchase	0	0	31	0	0	0	0	0	0	0	0	31	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,562	0	0	0	0	0	0	0	0	1,562	5
6	Maintenance	0	0	15,451	0	0	0	0	0	0	0	0	15,451	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	24,166	0	0	0	0	0	0	0	0	24,166	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,758	0	0	0	0	0	0	0	0	2,758	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	596	0	0	0	0	0	0	0	0	596	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	0	3,354	0	0	0	0	0	0	0	0	3,354	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	(1,494)	(186,115)	19,838	0	0	0	0	0	0	0	0	(167,771)	19
20	Fees, Subscriptions & Promotions	(23,017)	0	10,379	0	0	0	0	0	0	0	0	(12,638)	20
21	Clerical & General Office Expenses	0	0	295,275	0	0	0	0	0	0	0	0	295,275	21
22	Employee Benefits & Payroll Taxes	0	0	44,802	0	0	0	0	0	0	0	0	44,802	22
23	Inservice Training & Education	0	0	599	0	0	0	0	0	0	0	0	599	23
24	Travel and Seminar	(7,254)	0	7,081	0	0	0	0	0	0	0	0	(173)	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	11,189	0	0	0	0	0	0	0	0	11,189	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,765)	(186,115)	389,163	0	0	0	0	0	0	0	0	171,283	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,765)	(186,115)	416,683	0	0	0	0	0	0	0	0	198,803	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	0	0	18,950	0	0	0	0	0	0	0	18,950	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,603)	0	0	430	0	0	0	0	0	0	0	(26,173)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,682	0	0	0	0	0	0	0	6,682	34
35	Rent-Equipment & Vehicles	0	0	0	4,754	0	0	0	0	0	0	0	4,754	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,603)	0	0	30,816	0	0	0	0	0	0	0	4,213	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	11,557	0	0	0	0	0	0	0	0	0	11,557	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	11,557	0	0	0	0	0	0	0	0	0	11,557	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(58,368)	(174,558)	416,683	30,816	0	0	0	0	0	0	0	214,573	45

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [x] 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	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	11,557	11,557	2
3	V								3
4	V	19	Adjustment for Related Organization	186,115	Heritage Operations Group, LLC	0.00%		(186,115)	4
5	V								5
6	V	34	Adjustment for Related Organization		Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			$ 186,115			$ 11,557	$ * (174,558)	14

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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [x] 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)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 7,118	15
16	V	2	Food Purchase					31	16
17	V	3	Housekeeping					4	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,562	19
20	V	6	Maintenance					15,451	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					2,758	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					596	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					19,838	31
32	V	20	Fees, Subscription, Promotions					10,379	32
33	V	21	Clerical & General Office Expenses					295,275	33
34	V	22	Employee Benefits & Payroll Taxes					44,802	34
35	V	23	Inservice Training & Education					599	35
36	V	24	Travel and Seminar					7,081	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					11,189	38
39	Total			$			$ 0	$ * 416,683	39

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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [x] 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)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$	$	15
16	V	30	Depreciation					18,950	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					430	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,682	20
21	V	35	Rent-Equipment & Vehicles					4,754	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	$ * 30,816	39

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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					$		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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [x] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,604	24	$ 183,508	$ 183,106	101	$ 7,118	1
2	2	Food Purchase	Beds	2,604	24	798	0	101	31	2
3	3	Housekeeping	Beds	2,604	24	106	0	101	4	3
4	4	Laundry	Beds	2,604	24	0	0	101	0	4
5	5	Heat & Other Utilities	Beds	2,604	24	40,282	0	101	1,562	5
6	6	Maintenance	Beds	2,604	24	398,350	84,311	101	15,451	6
7	7	Other	Beds	2,604	24	0	0	101	0	7
8	9	Medical Director	Beds	2,604	24	0	0	101	0	8
9	10	Nursing & Medical Records	Beds	2,604	24	71,096	69,815	101	2,758	9
10	11	Activities	Beds	2,604	24	0	0	101	0	10
11	12	Social Service	Beds	2,604	24	0	0	101	0	11
12	13	Nurse Aide Training	Beds	2,604	24	15,364	15,279	101	596	12
13	14	Program Transportation	Beds	2,604	24	0	0	101	0	13
14	15	Other	Beds	2,604	24	0	0	101	0	14
15	17	Administrative	Beds	2,604	24	0	0	101	0	15
16	18	Directors Fees	Beds	2,604	24	0	0	101	0	16
17	19	Professional Services	Beds	2,604	24	511,456	0	101	19,838	17
18	20	Fees, Subscription, Promotions	Beds	2,604	24	267,591	0	101	10,379	18
19	21	Clerical & General Office Expens	Beds	2,604	24	7,612,820	7,140,260	101	295,275	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,604	24	1,155,097	0	101	44,802	20
21	23	Inservice Training & Education	Beds	2,604	24	15,452	0	101	599	21
22	24	Travel and Seminar	Beds	2,604	24	182,552	0	101	7,081	22
23	25	Other Admin. Staff Transportatio	Beds	2,604	24	0	0	101	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,604	24	288,473	0	101	11,189	24
25	TOTALS					$ 10,742,945	$ 7,492,771		$ 416,683	25

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [x] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,604	24	$	$	101	$	1
2	30	Depreciation	Beds	2,604	24	488,578		101	18,950	2
3	31	Amortization of Pre-Op & Org	Beds	2,604	24			101		3
4	32	Interest	Beds	2,604	24	11,093		101	430	4
5	33	Real Estate Taxes	Beds	2,604	24			101		5
6	34	Rent-Facility & Grounds	Beds	2,604	24	172,279		101	6,682	6
7	35	Rent-Equipment & Vehicles	Beds	2,604	24	122,579		101	4,754	7
8	36	Other	Beds	2,604	24			101		8
9	38	Medically Nec Transportation	Beds	2,604	24			101		9
10	39	Ancillary Service Centers	Beds	2,604	24			101		10
11	40	Barber and Beauty Shops	Beds	2,604	24			101		11
12	41	Coffee and Gift Shops	Beds	2,604	24			101		12
13	42	Other	Beds	2,604	24			101		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					$ 794,529	$		$ 30,816	25

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							21,311	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 21,311	9
	B. Non-Facility Related*											
10	Interest Income										(26,603)	10
11												11
12	Allocated Corporate										430	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,173)	14
15	TOTALS (line 9+line14)						$	$			$ (4,862)	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.)**

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 68,911	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.)		$ 67,460	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,451)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,832	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.		$ 69,381	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010	68,442	10
2011	65,629	11
2012	67,460	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-LaSalle COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0051276

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1709461000		$ 67,460.00	$ 67,460.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,460.00	$ 67,460.00

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 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. [x] (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. [x] (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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater			2011	9,850						9
10	Kitchen Drain Line			2011	8,681						10
11	Generator			2011	9,025						11
12	Walk-in cooler condensor			2011	4,877						12
13											13
14	Generator			2012	41,925						14
15	Sprinkler Heads			2012	15,610						15
16	Water Softener			2012	9,361						16
17	Lighting Upgrade			2012	5,362						17
18											18
19	Roof Replacement			2013	299,826						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	C/O Allocation					18,950		18,950			33
34	Book Depreciation					8,645		8,645			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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 404,517	$ 27,595		$ 27,595	$	$	70

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

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 76,480	$ 10,926	$ 10,926	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 76,480	$ 10,926	$ 10,926	$		$	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)	$ 480,997	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,521	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,521	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	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.

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LPRE Holdings, LLC
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. [x] 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:				$ 353,172			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 353,172 **			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: [x] YES [ ] NO Terms: 3500000 *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 8,681 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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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.

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 118,335	$		$ 118,335	1
2	Licensed Speech and Language Development Therapist		hrs			3,853			3,853	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			146,723	0		146,723	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				255,644		255,644	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					5,992			5,992	13
14	TOTAL			$		$ 274,903	$ 255,644		$ 530,547	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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 615	$	1
2	Cash-Patient Deposits	14,855		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	728,666		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,956		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,092,919)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (343,827)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	404,517		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	76,480		16
17	Accumulated Depreciation (book methods)	(45,019)		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)**	$ 435,978	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 92,151	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,303	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,855		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	180,338		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,117		31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,832		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Assessment Tax	86,473		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 457,918	$	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)**	$ 457,918	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (365,767)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 92,151	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (99,171)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (99,171)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(266,596)	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)**	$ (266,596)	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)**	$ (365,767)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,943,151	1
2	Discounts and Allowances for all Levels	(1,026,131)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,917,020	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	893,850	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 893,850	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,905	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	477,981	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	130	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 481,016	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,603	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,318,489	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	778,158	31
32	Health Care	2,291,243	32
33	General Administration	1,046,804	33
	B. Capital Expense		
34	Ownership	472,116	34
	C. Ancillary Expense		
35	Special Cost Centers	(3,236)	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,585,085	40
41	**Income before Income Taxes (line 30 minus line 40)****	(266,596)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (266,596)	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-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,024	$ 64,114	$ 31.68	1
2	Assistant Director of Nursing	1,928	1,936	54,972	28.39	2
3	Registered Nurses	8,660	9,088	241,638	26.59	3
4	Licensed Practical Nurses	16,821	18,359	397,284	21.64	4
5	CNAs & Orderlies	60,666	63,715	718,922	11.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,930	2,033	58,190	28.62	8
9	Activity Director					9
10	Activity Assistants	6,299	6,815	84,276	12.37	10
11	Social Service Workers	1,715	1,836	23,706	12.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,041	16,387	192,113	11.72	15
16	Dishwashers					16
17	Maintenance Workers	5,360	5,745	77,939	13.57	17
18	Housekeepers	6,357	7,047	60,656	8.61	18
19	Laundry	5,434	5,831	54,692	9.38	19
20	Administrator	1,900	2,080	83,056	39.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,231	8,076	159,321	19.73	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)	141,246	150,972	$ 2,270,879 *	$ 15.04	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		24,000		36
37	Medical Records Consultant		6,942		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,060		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		2,677		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,679		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Walsh			$ 83,056
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,056

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 186,115
Legal adj to Zero		1,494
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 187,609

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,527
Unemployment Compensation Insurance	44,921
FICA Taxes	173,722
Employee Health Insurance	189,509
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	13,131
Central Office Allocation	44,802
TOTAL (agree to Schedule V, line 22, col.8)	$ 492,612

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,609
Health Care Worker Background Check	
(Indicate # of checks performed)	1,470
Patient Background Checks	
	4,356
Dues & Subscriptions	6,746
License & Fees	4,937
Central Office Allocation	10,379
Less: Public Relations Expense	(4,356)
Non-allowable advertising	(1,115)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,026

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,671
	0
Seminar Expense	501
	(173)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Health-LaSalle # 0051276 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Yrs.**

(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? **No**
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. $ **55,298**
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? **No** 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. $ Has any meal income been offset against related costs? Indicate the amount. $ **245**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** 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?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. $ **0**

(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	615						1,009	1,009	PETTY C	615
1010	CASH IN BANK							1,100	1,100	ACCTS R	728,666
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	728,666						1,110	1,110	ACCTS RECEIV-M/C	
1110	MEDICARE RECEIVABLES							1,125	1,125	ACCTS RECEIV-IPA	
1125	IPA INCOME RECEIVABLE							1,135	1,135	ACCTS RECEIV-IC	
1130	MEDICARE COST REPORT							1,140	1,140	UNAPPLIED CASH RECEIPTS	
1135	ACCOUNTS RECEIVABLE-IC							1,145	1,145	A/R SUSPENSE-REFUNDS	
1140	UNAPPLIED CASH RECEIPTS							1,200	1,200	PREPAID	4,956
1145	A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES	
1190	ACCRUED INTEREST REC							1,300	1,300	DIETARY INVENTORY	
1200	PREPAID INSURANCE	4,956						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	76,480
1409	LAND	0						1,460			(29,760)
1450	FURNITURE & EQUIPMENT	76,480						1,475	1,475	CODE AI	404,517
1460	ACCUM DEPR-FURN & EQU	-29,760						1,490	1,490	ACCUM I	(15,259)
1475	BUILDING & IMPROVEMEN	404,517						1,530	1,530	RESIDEN	14,855
1490	ACCUM DEPR-BUILDING	-15,259						1,550	1,550	LOAN FE	0
1530	RESIDENT FUNDS	14,855						1,551	1,551	LOAN FEES ADDED	
1550	LOAN FEES	0						1,850	1,850	INTERCC	(1,092,919)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	(100,303)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-1,092,919						2,100	2,100	ACCRUE	(64,761)
2010	ACCOUNTS PAYABLE	-100,303						2,100	2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-64,761						2,110	2,110	ACCRUE	(115,577)
2110	ACCRUED VACATION PAY	-115,577						2,120	2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-5,117	-5,117
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYA	0	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-86,473	
2350	REAL ESTATE TAX PAYAB	-70,832	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-14,855	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	99,171	
2970	PROFIT/LOSS FOR PERIOD	266,596	
3007.1	PATIENT DAYS-PRIVATE	4,137	

2,125	2,125	FICA TA:	(5,117)
2,130	2,130	FEDERAL W/H TAX PAYABLI	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE RE:	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETI	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNISHMENT	
2,300	2,300	ACCRUE	0
2,320	2,320	IPA PAYI	(86,473)
2,350	2,350	REAL ES	(70,832)
2,385			0
2,400	2,400	CURRENT PORTION OF LT DI	
2,512	2,512	DUE TO I	(14,855)
2,600	2,600	LASALLI	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DI	
2,720	2,720	RETAINI	99,171
		net incom	266,596
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	23,955					3,007
3007.3		PATIENT DAYS-MEDICARE	1,999					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 &	-3,935,271	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	-7,721	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	-477,981	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-893,850	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	1,026,131	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	0		0	0	0	0		3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570		12	VENDING INCOME/EXPENS	-2,905		0	0	0	0		3,590
3580		12	MANAGEMENT FEES			0	0	0	0		3,595
3590		1	EQUIPMENT RENTAL	-159		0	0	0	0		3,600
3595		21	RESIDENT TRANSPORTATI	105		0	0	0	0		4,110
3600		21	MISC INCOME	-235		0	0	0	0		4,111
4110			GENERAL & ADMINIST WA	153,284	159,321	21	1	17	0		4,115
4111			ADMINISTRATOR WAGES	83,056	83,056	17	1	0	0		4,120
4115			VACATION & SICK - G&A	6,037		21	1	0	0		4,125
4120	4475		EMPLOYEE BENEFITS	10,720	447,810	22	3	0	0		4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0		4,135
4130			EMPLOYEE SCHOLORSHIP	2,113		21	1	0	0		4,250
4135			EMPLOYEE SCHOLORSHIP	298		23	3	0	0		4,255
4220			DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255		OFFICE SUPPLIES	19,478	19,478	21	2	0	0		4,275
4260			TELEPHONE	10,471	10,471	21	3	0	0	**	4,276
4275			TRAINING & EMPLOYEE D	4,954	4,954	23	3	16	0		4,280
4280			GENERAL TRAVEL	1,671	2,172	24	3	16	0		4,281
4281			MEAL EXPENSE FOR TRAV	0		24	3	19	0	***	4,285
4285			EDUCATION & SEMINAR	501		24	3	19	-7,254		4,289
4290			HELP WANTED ADVERTISI	1,609	91,962	20	3	0	0	-55,298	4,290
4291			PROMOTIONAL ADVERTIS	17,546		20	3	25	-17,546		4,291
4292			PUBLIC RELATIONS	4,356		20	3	25	-4,356		4,292
4300			LICENSES & FEES	60,235		20	3	17	0		4,300
4310			DUES & SUBSCRIPTIONS	6,746		20	3	17	-1,115		4,310
4320			CONTRIBUTIONS	0		27	3	20	0		4,320
4350			PROFESSIONAL FEES	1,494	187,609	19	3	22	-1,494		4,350
4355			MEDICAL DIRECTOR	24,000	24,000	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	6,942		10	3	0	0	4,364
4363	PHARMACIST FEES	6,060		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	2,677	2,677	12	3	0	0	4,383
4370	TV RENTAL	7,114		35	3	5	0	4,390
4380	INCOME TAXES		0	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,470		20	3	26	0	4,401
4400	PAYROLL TAXES	210,022		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,621		22	3	0	0	4,420
4410	GROUP INSURANCE	189,509		22	3	0	0	4,430
4420	LIABILITY INSURANCE	39,971	39,971	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	26,527		22	3	0	0 **	4,450
4450	CENTRAL OFFICE FEES	186,115		19	3	34	0	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	69,381	69,381	33	3	0	0	4,486
4600	LEASED EQUIPMENT	1,567	8,681	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	72,942	77,939	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,997		6	1	0	0	4,510
5130	ELECTRIC	26,889	94,243	5	3	0	0	4,600
5131	NATURAL GAS	18,982		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	48,372		5	3	0	0	5,130
5134	TRASH COLLECTION	18,757	61,190	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	3,187	22,425	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	19,238		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	42,433		6	3	0	0	5,140
5210	DIETARY WAGES	178,663	192,113	1	1	0	0	5,160
5220	DIETARY SICK & VAC	13,450		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	169,060	168,815	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	1,832	7,987	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	19		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	6,136		1	2	0	0	5,260
5295	MEAL CREDIT	-245		2	2	0	0	5,270
5310	LAUNDRY WAGES	50,195	54,692	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,497		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	5,214	14,530	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	9,316		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	57,673	60,656	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	2,983		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	13,761	23,568	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	9,807		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,535,120	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	219,286		10	1	0	0	6,020
6030	DON WAGES	64,114		10	1	0	0	6,030
6035	ADON	54,972		10	1	0	0	6,035
6040	RN SICK & VACATION	22,352		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	371,008		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	26,276		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC	683,270		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	35,652		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	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	53,912		10	1	0	0	6,390
6275	REHAB SICK & VAC	4,278		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0		7,280
6290	NURSING SUPPLIES	-792	76,083	10	2	0	0		7,281
6295	NURSING SUPPLIES	68,348		10	2	0	0		7,380
6390	REPLACEMENT-NURSING	8,527		10	2	0	0		7,391
6490	NURSING OTHER	167	13,169	10	3	0	0	***	7,393
7280	DRUG PURCHASES	72,453	255,644	39	2	0	0		7,510
7281	DRUG PURCHASES-OTHER	183,191		39	2				7,540
7380	LABORATORY SERVICES	5,992	274,903	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	77,274	84,276	11	1	0	0		7,720
7540	ACTIVITIES SICK & VAC	7,002		11	1	0	0		7,730
7590	ACTIVITIES SUPPLIES	1,665	1,665	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	146,723		39	3	0	0		7,890
7660	PT SUPPLIES	0		39	2	0	0		7,960
7710	SOCIAL SERVICE WAGES	22,050	23,706	12	1	0	0		8,120
7720	SOCIAL SERVICE SICK & V	1,656		12	1	0	0		8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	***	8,130
7740	OT FEE	118,335		39	3	0	0		8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	***	9,510
7770	SPEECH THERAPY FEE	3,853		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	-3,236	-3,236	40	3	0	0		
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910	VOLUNTEER COORDINATOR			21	1	0	0		
7940	VOL COORD SICK & VAC			21	1	0	0		
7960	VOL COORD SUPPLIES	0		21	2	0	0		
8100	RENT	353,172	353,172	34	3	0	0		

8120	INTEREST EXPENSE	21,311	21,311	32	3	14	-26,603
8130	DEPRECIATION	19,571	19,571	30	3	9	0
8150	LOAN FEE AMORTIZATION	0		32	3	0	0
9510	INTEREST INCOME	-26,603		32	0	10	0
9520	MISC NON-OPERATING INC	0		0	0	0	0
9700	INCOME TAXES	0		0	0	0	0
		4,558,482	4,585,085				
			26,603				
GRAND TOTALS		266,596					-58,368
		(NET INCOME)					
		0					

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 101

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	4,137	4,137
IPA	23,955	23,955
medicare	1,999	1,999
		30,091

IPA BEDHOLDS 0
PP BEDHOLDS 0
PP CONVERS 0

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FUND

ERIA

EBT

EBT

3,007 PATIENT 4,137

3,007	PATIENT	23,955
3,007	PATIENT	1,999
		0
3,010	BASIC CH	(3,935,271)
3,020	BASIC CH	0
3,030	BASIC CH	0
		0
		0
		0
		0
3,080	NURSING	(7,721)
3,081	NURSING	0
3,082	NURSING	0
3,083	NURSING	0
3,100	DRUGS-M	(477,981)
		0
3,110	PHYSICAL	(893,850)
		0
3,112	PHYSICAL	0
3,113	PHYSICAL	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTHE	0
3,411	MEDICAR	0
3,420	MEDICAR	938,841

3,520	RENT INC	0
3,530	BEAUTY S	0
		0
3,570	VENDING	(2,905)
3,590	EQUIPME	(159)
3,595	RESIDENT	105
3,600	MISC INC	(235)
4,110	G&A WAG	153,284
4,111	ADMINIST	83,056
4,115	G&A PTO	6,037
4,120	EMPLOYE	10,761
4,130	EMPLOYE	2,113
4,135	EMPLOYE	298
4,250	OFFICE SU	8,123
4,255	POSTAGE	2,443
4,260	TELEPHO	10,471
4,275	TRAININ(	4,954
		0
4,280	GENERAI	1,671
4,281	MEAL EX	0
4,285	EDUCATI	501
4,289	MEETING	0
4,290	HELP WA	1,609
4,291	PROMOTI	17,546
4,292	PUBLIC R	4,356
4,300	LICENSE	60,235
4,310	DUES & S	6,746
4,320	CONTRIB	0
4,350	PROFESSI	1,494
4,355	MEDICAL	24,000
		6,942
		6,060

4,364	SOCIAL S	2,677
4,370	TV RENT/	7,114
4,383	BACKGR(	1,470
4,390	OTHER T/	0
4,400	PAYROLL	210,022
4,401	PAYROLL	8,621
4,410	GROUP IN	189,509
4,420	LIABILIT'	39,971
4,430	WORKMA	24,787
4,435	W/C-FIRS'	357
4,436	DRUG TE:	1,383
4,450	MANAGE	186,115
4,460	BAD DEB'	0
4,461	BAD DEB'	87,290
4,470	LOST ITE:	0
4,475	UNIFORM	(41)
4,486	SERVICE	19,703
4,490	MISC EXP	159
4,496	MISC. M.I	8,912
4,510	REAL EST	69,381
4,600	LEASED E	1,567
5,110	MAINTEN	72,942
5,120	MAINTEN	4,997
5,130	ELECTRI(	26,889
5,131	NATURAL	18,982
5,133	WATER &	48,372
5,134	TRASH C(	18,757
5,140	PROP/PLA	3,187
5,160	GENERAL	19,238
5,165	MAINTEN	22,730
5,210	DIETARY	178,663
5,220	DIETARY	13,450
5,248	FOOD PU	168,901

5,250	SUPPLIES	1,832
5,260	REPLACE	19
5,270	KITCHEN	6,136
5,295	MEAL INC	(245)
5,310	LAUNDRY	50,195
5,340	LAUNDRY	4,497
5,370	REPLACE	5,214
		93
5,390	SUPPLIES	9,223
5,410	HOUSEKE	57,673
5,440	HOUSEKE	2,983
5,480	SUPPLIES	13,761
5,490	SUPPLIES	9,807
6,020	RN WAGE	219,286
6,030	DON WAC	64,114
6,035	ADON WA	54,972
6,040	RN PTO &	22,352
6,120	LPN WAG	371,008
6,140	LPN PTO	26,276
6,220	AIDES WA	683,270
6,240	AIDES PT	35,652
		0
		0
		0
		0
6,270	REHAB W	53,912
6,275	REHAB PT	4,278
6,290	NURSING	(792)
6,295	NURSING	68,348
6,390	REPLACE	8,527
6,490	OTHER	167

7,280	DRUG PU	72,453
7,281	DRUG PU	183,191
7,380	LABORAT	3,889
7,390	X-RAY SE	885
		1,218
7,510	ACTIVITI	77,274
7,540	ACTIVITI	7,002
7,590	ACTIVITI	1,665
7,620	PHYSICAL	146,723
7,660	P.T. SUPP	0
7,710	SOCIAL S	22,050
7,720	SOCIAL S	1,656
7,730	SOCIAL S	0
7,740	OCCUPAT	118,335
7,770	SPEECH T	3,853
7,820	BEAUTIC	(3,236)
		0
		0
8,120	INTEREST	0
		21,311
8,130	DEPRECI	19,571
		0
9,510	INTEREST	(26,603)
9,520	MISC NOI	0
4,220		0
8,100		353,172
9,702		0
5,230		0
		266,596

Expenses Fixed Assets

Related Parties
From Page 6

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