FOR BHF USE

LL1

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: 0041699

Facility Name: Heritage Health-Springfield

Address: 900 North Rutledge (Number) Springfield (City) 62702 (Zip Code)

County: Sangamon

Telephone Number: ( ) **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1996

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-Springfield # 0041699 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	178	Skilled (SNF)	178	64,970	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	178	TOTALS	178	64,970	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	33,669	12,062	10,196	55,927	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,669	12,062	10,196	55,927	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.08%

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 1996

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 10,196

Medicare Intermediary _____

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-Springfield # 0041699 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	364,328	26,778		391,106		391,106	12,544	403,650			1
2	Food Purchase		377,874		377,874		377,874	55	377,929			2
3	Housekeeping	210,629	61,029		271,658		271,658	7	271,665			3
4	Laundry	111,649	26,574		138,223		138,223		138,223			4
5	Heat and Other Utilities			222,982	222,982		222,982	2,754	225,736			5
6	Maintenance	147,175	81,613	114,423	343,211		343,211	27,230	370,441			6
7	Other (specify):*											7
8	TOTAL General Services	833,781	573,868	337,405	1,745,054		1,745,054	42,590	1,787,644			8
	B. Health Care and Programs											
9	Medical Director			16,650	16,650		16,650		16,650			9
10	Nursing and Medical Records	3,472,668	302,359	21,068	3,796,095		3,796,095	4,860	3,800,955			10
10a	Therapy		1,150,013	1,010,999	2,161,012	(1,199,392)	961,620		961,620			10a
11	Activities	108,762	3,674		112,436		112,436		112,436			11
12	Social Services	65,284		3,113	68,397		68,397		68,397			12
13	CNA Training							1,050	1,050			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,646,714	1,456,046	1,051,830	6,154,590	(1,199,392)	4,955,198	5,910	4,961,108			16
	C. General Administration											
17	Administrative	85,629			85,629		85,629		85,629			17
18	Directors Fees											18
19	Professional Services			443,332	443,332		443,332	(388,156)	55,176			19
20	Dues, Fees, Subscriptions & Promotions			141,159	141,159	(97,455)	43,704	4,874	48,578			20
21	Clerical & General Office Expenses	471,829	45,638	64,671	582,138		582,138	520,385	1,102,523			21
22	Employee Benefits & Payroll Taxes			1,101,125	1,101,125		1,101,125	78,958	1,180,083			22
23	Inservice Training & Education			11,076	11,076		11,076	1,056	12,132			23
24	Travel and Seminar			3,823	3,823		3,823	(1,824)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			211,503	211,503		211,503	19,719	231,222			26
27	Other (specify):*			30,618	30,618		30,618	(30,000)	618			27
28	TOTAL General Administration	557,458	45,638	2,007,307	2,610,403	(97,455)	2,512,948	205,012	2,717,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,037,953	2,075,552	3,396,542	10,510,047	(1,296,847)	9,213,200	253,512	9,466,712			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-Springfield #0041699 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			309,801	309,801		309,801	33,397	343,198			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,225	70,225		70,225	(77,860)	(7,635)			32
33	Real Estate Taxes			120,054	120,054		120,054		120,054			33
34	Rent-Facility & Grounds							11,776	11,776			34
35	Rent-Equipment & Vehicles			13,726	13,726		13,726	8,379	22,105			35
36	Other (specify):*											36
37	**TOTAL Ownership**			513,806	513,806		513,806	(24,308)	489,498			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					1,199,392	1,199,392	(204,585)	994,807			39
40	Barber and Beauty Shops			21,889	21,889		21,889		21,889			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,455	97,455		97,455			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			21,889	21,889	1,296,847	1,318,736	(204,585)	1,114,151			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,037,953	2,075,552	3,932,237	11,045,742		11,045,742	24,619	11,070,361			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-Springfield # 0041699 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	(78,618)			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	(1,274)			17
18	Fines and Penalties				18
19	Entertainment	(14,303)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,401)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)			24
25	Fund Raising, Advertising and Promotional	(12,144)			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)**	$ (154,740)		$	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)	179,359		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 179,359		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 24,619		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

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Heritage Health-Springfield

ID# **0041699**

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		(1,274)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(18,401)	19	22
23				23
24		(30,000)	27	24
25		(12,144)	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**	(61,819)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Springfield **#** 0041699 **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 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	12,544	0	0	0	0	0	0	0	0	12,544	1
2	Food Purchase	0	0	55	0	0	0	0	0	0	0	0	55	2
3	Housekeeping	0	0	7	0	0	0	0	0	0	0	0	7	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,754	0	0	0	0	0	0	0	0	2,754	5
6	Maintenance	0	0	27,230	0	0	0	0	0	0	0	0	27,230	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	42,590	0	0	0	0	0	0	0	0	42,590	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	4,860	0	0	0	0	0	0	0	0	4,860	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	1,050	0	0	0	0	0	0	0	0	1,050	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	5,910	0	0	0	0	0	0	0	0	5,910	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	(18,401)	(404,716)	34,961	0	0	0	0	0	0	0	0	(388,156)	19
20	Fees, Subscriptions & Promotions	(13,418)	0	18,292	0	0	0	0	0	0	0	0	4,874	20
21	Clerical & General Office Expenses	0	0	520,385	0	0	0	0	0	0	0	0	520,385	21
22	Employee Benefits & Payroll Taxes	0	0	78,958	0	0	0	0	0	0	0	0	78,958	22
23	Inservice Training & Education	0	0	1,056	0	0	0	0	0	0	0	0	1,056	23
24	Travel and Seminar	(14,303)	0	12,479	0	0	0	0	0	0	0	0	(1,824)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	19,719	0	0	0	0	0	0	0	0	19,719	26
27	Other (specify):*	(30,000)	0	0	0	0	0	0	0	0	0	0	(30,000)	27
28	**TOTAL General Administration**	(76,122)	(404,716)	685,850	0	0	0	0	0	0	0	0	205,012	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(76,122)	(404,716)	734,350	0	0	0	0	0	0	0	0	253,512	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Springfield **#** 0041699 **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 D. Ownership	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)	
30	Depreciation	0	0	0	33,397	0	0	0	0	0	0	0	33,397	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(78,618)	0	0	758	0	0	0	0	0	0	0	(77,860)	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	11,776	0	0	0	0	0	0	0	11,776	34
35	Rent-Equipment & Vehicles	0	0	0	8,379	0	0	0	0	0	0	0	8,379	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(78,618)	0	0	54,310	0	0	0	0	0	0	0	(24,308)	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	(204,585)	0	0	0	0	0	0	0	0	0	(204,585)	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	(204,585)	0	0	0	0	0	0	0	0	0	(204,585)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(154,740)	(609,301)	734,350	54,310	0	0	0	0	0	0	0	24,619	45

Facility Name & ID Number Heritage Health-Springfield # 0041699 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. ☐ 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%	(204,585)	(204,585)	2
3	V								3
4	V	19	Adjustment for Related Organization	404,716	Heritage Operations Group, LLC	0.00%		(404,716)	4
5	V								5
6	V	34	Adjustment for Related Organization		Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			$ 404,716			$ (204,585)	$ * (609,301)	14

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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.		$	$ 12,544	15
16	V	2	Food Purchase					55	16
17	V	3	Housekeeping					7	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					2,754	19
20	V	6	Maintenance					27,230	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					4,860	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,050	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					34,961	31
32	V	20	Fees, Subscription, Promotions					18,292	32
33	V	21	Clerical & General Office Expenses					520,385	33
34	V	22	Employee Benefits & Payroll Taxes					78,958	34
35	V	23	Inservice Training & Education					1,056	35
36	V	24	Travel and Seminar					12,479	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					19,719	38
39	Total			$			$ 0	$ * 734,350	39

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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. ☐ 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.		$	$ 0	15
16	V	30	Depreciation					33,397	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					758	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					11,776	20
21	V	35	Rent-Equipment & Vehicles					8,379	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	$ * 54,310	39

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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-Springfield # 0041699 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-Springfield # 0041699 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	178	$ 12,544	1
2	2	Food Purchase	Beds	2,604	24	798	0	178	55	2
3	3	Housekeeping	Beds	2,604	24	106	0	178	7	3
4	4	Laundry	Beds	2,604	24	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,604	24	40,282	0	178	2,754	5
6	6	Maintenance	Beds	2,604	24	398,350	84,311	178	27,230	6
7	7	Other	Beds	2,604	24	0	0	178	0	7
8	9	Medical Director	Beds	2,604	24	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,604	24	71,096	69,815	178	4,860	9
10	11	Activities	Beds	2,604	24	0	0	178	0	10
11	12	Social Service	Beds	2,604	24	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,604	24	15,364	15,279	178	1,050	12
13	14	Program Transportation	Beds	2,604	24	0	0	178	0	13
14	15	Other	Beds	2,604	24	0	0	178	0	14
15	17	Administrative	Beds	2,604	24	0	0	178	0	15
16	18	Directors Fees	Beds	2,604	24	0	0	178	0	16
17	19	Professional Services	Beds	2,604	24	511,456	0	178	34,961	17
18	20	Fees, Subscription, Promotions	Beds	2,604	24	267,591	0	178	18,292	18
19	21	Clerical & General Office Expens	Beds	2,604	24	7,612,820	7,140,260	178	520,385	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,604	24	1,155,097	0	178	78,958	20
21	23	Inservice Training & Education	Beds	2,604	24	15,452	0	178	1,056	21
22	24	Travel and Seminar	Beds	2,604	24	182,552	0	178	12,479	22
23	25	Other Admin. Staff Transportatio	Beds	2,604	24	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,604	24	288,473	0	178	19,719	24
25	TOTALS					$ 10,742,945	$ 7,492,771		$ 734,350	25

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	$	$	178	$	1
2	30	Depreciation	Beds	2,604	24	488,578		178	33,397	2
3	31	Amortization of Pre-Op & Org	Beds	2,604	24			178		3
4	32	Interest	Beds	2,604	24	11,093		178	758	4
5	33	Real Estate Taxes	Beds	2,604	24			178		5
6	34	Rent-Facility & Grounds	Beds	2,604	24	172,279		178	11,776	6
7	35	Rent-Equipment & Vehicles	Beds	2,604	24	122,579		178	8,379	7
8	36	Other	Beds	2,604	24			178		8
9	38	Medically Nec Transportation	Beds	2,604	24			178		9
10	39	Ancillary Service Centers	Beds	2,604	24			178		10
11	40	Barber and Beauty Shops	Beds	2,604	24			178		11
12	41	Coffee and Gift Shops	Beds	2,604	24			178		12
13	42	Other	Beds	2,604	24			178		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 794,529	$		$ 54,310	25

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	Bank of Springfield		x	Mortgage			$	$ 1,544,105			$ 70,225	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,544,105			$ 70,225	9
	B. Non-Facility Related*											
10	Interest Income										(78,618)	10
11												11
12	Allocated Corporate										758	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (77,860)	14
15	TOTALS (line 9+line14)						$	$ 1,544,105			$ (7,635)	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-Springfield # 0041699 **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.**	$ 128,752	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.)		$ 125,712	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,040)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 131,997	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** $ 8,903 **For** 2010 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (8,903)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 120,054	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	124,588	8
	2009	126,452	9
	2010	119,559	10
	2011	122,620	11
	2012	125,712	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-Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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.	14280277027		$ 125,712.00	$ 125,712.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 125,712.00	$ 125,712.00

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 x _____ 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-Springfield # 0041699 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,805 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4

C. Does the Operating Entity? [x] (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? [x] (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 [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				$ 630,000	1
2					2
3	TOTALS			$ 630,000	3

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	178				$ 1,900,000	$		$	$	$	4
5					1,648,258						5
6											6
7											7
8											8
	Improvement Type**										
9	1985 Improvements			1985	26,076						9
10	1986 Improvements			1986	216,545						10
11	1987 Improvements			1987	593,121						11
12	1988 Improvements			1988	29,321						12
13	1989 Improvements			1989	1,095						13
14	1990 Improvements			1990	939						14
15	1991 Improvements			1991	32,022						15
16	1992 Improvements			1992	32,593						16
17	1993 Improvements			1993	105,986						17
18	1994 Improvements			1994	59,542						18
19	1995 Improvements			1995	36,126						19
20	Laundry Chute			1996	4,926						20
21	Door Alarm			1996	8,533						21
22	Garbage Disposal			1996	1,113						22
23	Elevator			1996	11,439						23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation					33,397		33,397			33
34	Book Depreciation					245,544		245,544			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-Springfield # 0041699 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	Vent Shaft	1997	$ 6,267	$		$	$	$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,668,973	$ 278,941		$ 278,941	$	$	70

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	
1	Totals from Page 12A, Carried Forward		$ 5,668,973	$ 278,941		$ 278,941	$	$	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11									11
12	Door Replacement	2003	1,216						12
13									13
14									14
15	Shower Room Remodel	2003	14,285						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	36,919						19
20	Elevator Repair	2004	74,457						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24	Controller board	2005	2,460						24
25	Wall Railing	2005	2,837						25
26	A/C Protection	2005	1,318						26
27	Compressor	2005	10,800						27
28	Chiller	2005	2,305						28
29	Rooftop Compressor	2005	4,676						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,050,204	$ 278,941		$ 278,941	$	$	34

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	
1	Totals from Page 12B, Carried Forward		$ 6,050,204	$ 278,941		$ 278,941	$	$	1
2	Sprinkler system	2006	250,656						2
3	Door Alarm	2006	2,940						3
4	Stair Treads	2006	12,497						4
5	Roof	2006	2,219						5
6	Fire door	2006	6,154						6
7									7
8	HVAC Controls								8
9		2007	12,375						9
10	Sprinkler system	2007							10
11	Circulating pump	2007	12,140						11
12		2007	2,693						12
13	Walk-in freezer	2007							13
14	Fire Alarm	2007	24,013						14
15	Exit Lighting	2007							15
16		2007							16
17	HVAC								17
18		2007	18,080						18
19	Window treatments	2007							19
20		2007	3,431						20
21	Beauty Shop sink,vanity, painting								21
22		2008	1,597						22
23									23
24	HVAC								24
25	Elevator	2009	11,480						25
26	Boiler	2009	53,743						26
27	Asphalt	2009	2,914						27
28		2009	9,138						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,476,274	$ 278,941		$ 278,941	$	$	34

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	
1	Totals from Page 12C, Carried Forward		$ 6,476,274	$ 278,941		$ 278,941	$	$	1
2									2
3	Elevator	2010	71,294						3
4	Water storage tank	2010	16,211						4
5	paging system	2010	2,642						5
6	water heater	2010	13,740						6
7	dinning room window	2010	49,757						7
8	fire rated metal	2010	3,921						8
9	Aggregate column	2010	34,550						9
10	boiler	2010	3,255						10
11									11
12	100 gallon water heater	2011	8,958						12
13	Chiller	2011	11,556						13
14	Door & Installation	2011	4,361						14
15	Chiller Fan	2011	3,792						15
16	Smoke detector	2011	3,935						16
17	Sign	2011	3,250						17
18									18
19	Lighting upgrade	2012	17,773						19
20	Nurse Call	2012	5,107						20
21									21
22	Nurse Call System Install- Second Floor	2013	13,536						22
23	Extended Care Wing ALC Controls Installation	2013	25,930						23
24	Fire Alarm CPU Replacement	2013	2,761						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,772,603	$ 278,941		$ 278,941	$	$	34

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	$ 1,661,642	$ 64,257	$ 64,257	$		$	71
72	Current Year Purchases	25,159						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,686,801	$ 64,257	$ 64,257	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2008 Van		$ 38,949	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 38,949	$	$	$		$	80

E. Summary of Care-Related Assets

		1 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)	$ 9,128,353	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 343,198	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 343,198	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-Springfield # 0041699 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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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: $ 13,726 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-Springfield # 0041699 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-Springfield # 0041699 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	$		$ 416,652	$		$ 416,652	1
2	Licensed Speech and Language Development Therapist		hrs			86,190			86,190	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			458,263	515		458,778	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				1,149,498		1,149,498	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					49,894			49,894	13
14	TOTAL			$		$ 1,010,999	$ 1,150,013		$ 2,161,012	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-Springfield # 0041699 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	$ 1,230,486	$	1
2	Cash-Patient Deposits	22,123		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,894,403		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,446		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,618,582		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,840,040	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	6,878,870		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,725,749		16
17	Accumulated Depreciation (book methods)	(5,831,357)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,403,262	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,243,302	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 431,863	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,123		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	131,997		32
33	Accrued Interest Payable	4,908		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Assessment Tax	140,090		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 730,981	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,544,105		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,544,105	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,275,086	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,968,216	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,243,302	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health-Springfield # 0041699 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**	$ 5,045,686	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,045,686	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	922,530	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)**	$ 922,530	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,968,216	24 *

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

Facility Name & ID Number Heritage Health-Springfield # 0041699 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	$ 11,046,915	1
2	Discounts and Allowances for all Levels	(4,915,583)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,131,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,624,500	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,624,500	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	2,238	12
13	Barber and Beauty Care	26,665	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,109,264	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(2,180)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,135,987	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	78,618	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 78,618	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(1,719)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,719)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,968,718	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,745,054	31
32	Health Care	6,154,590	32
33	General Administration	2,610,403	33
	B. Capital Expense		
34	Ownership	513,806	34
	C. Ancillary Expense		
35	Special Cost Centers	21,889	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)***	$ 11,045,742	40
41	**Income before Income Taxes (line 30 minus line 40)****	922,976	41
42	**Income Taxes**	(446)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 922,530	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-Springfield # 0041699 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	2,214	$ 70,489	$ 31.84	1
2	Assistant Director of Nursing	6,775	6,940	176,581	25.44	2
3	Registered Nurses	18,250	20,303	517,225	25.48	3
4	Licensed Practical Nurses	45,932	49,269	1,047,264	21.26	4
5	CNAs & Orderlies	123,955	132,828	1,654,437	12.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	402	563	6,672	11.85	8
9	Activity Director					9
10	Activity Assistants	8,724	9,121	108,762	11.92	10
11	Social Service Workers	3,940	3,955	65,284	16.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,626	36,702	364,328	9.93	15
16	Dishwashers					16
17	Maintenance Workers	10,452	11,489	147,175	12.81	17
18	Housekeepers	19,088	20,284	210,629	10.38	18
19	Laundry	10,154	11,114	111,649	10.05	19
20	Administrator	1,900	2,080	85,629	41.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,952	23,086	471,829	20.44	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)	307,054	329,948	$ 5,037,953 *	$ 15.27	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		16,650		36
37	Medical Records Consultant		840		37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,680		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,113		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 31,283		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

Facility Name & ID Number Heritage Health-Springfield # 0041699 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keil Perigan			$ 85,629
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,629

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	$ 404,716
Sulaski & Webb	Audit	16,250
McQuellon Consulting	Consulting	3,965
Legal adj to Zero		18,401
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 443,332

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,727
Unemployment Compensation Insurance	104,216
FICA Taxes	385,403
Employee Health Insurance	451,957
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	27,822
Central Office Allocation	78,958
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,180,083

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,708
Health Care Worker Background Check	
(Indicate # of checks performed)	5,130
Patient Background Checks	
	10,522
Dues & Subscriptions	12,498
License & Fees	1,224
Central Office Allocation	18,292
Less: Public Relations Expense	(10,522)
Non-allowable advertising	(1,274)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,578

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,720
	31
Seminar Expense	2,072
	(1,824)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health-Springfield # 0041699 Report Period Beginning: 01/01/13 Ending: 12/31/13

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-Springfield # 0041699 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. $ **97,455**
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. $ **3,986**

(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	1,230,486					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	1,894,403					
1110	MEDICARE RECEIVABLES						
1125	IPA INCOME RECEIVABLE						
1130	MEDICARE COST REPORT						
1135	ACCOUNTS RECEIVABLE-IC						
1140	UNAPPLIED CASH RECEIPTS						
1145	A/R SUSPENSE-REFUNDS						
1190	ACCRUED INTEREST REC						
1200	PREPAID INSURANCE	74,446					
1220	OTHER PREPAID EXPENSES						
1300	FOOD INVENTORY						
1310	SUPPLIES INVENTORY						
1409	LAND	630,000					
1450	FURNITURE & EQUIPMENT	1,725,749					
1460	ACCUM DEPR-FURN & EQU	-1,525,590					
1475	BUILDING & IMPROVEMEN	6,878,870					
1490	ACCUM DEPR-BUILDING	-4,305,767					
1530	RESIDENT FUNDS	22,123					
1550	LOAN FEES	0					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	1,618,582					
2010	ACCOUNTS PAYABLE	-431,863					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	0					
2110	ACCRUED VACATION PAY	0					
1,009	1,009 PETTY C	1,230,486					
1,100	1,100 ACCTS R	1,894,403					
1,101	1,101 ALLOW. FOR UNCOLLECTIBI						
1,110	1,110 ACCTS RECEIV-M/C						
1,125	1,125 ACCTS RECEIV-IPA						
1,135	1,135 ACCTS RECEIV-IC						
1,140	1,140 UNAPPLIED CASH RECEIPTS						
1,145	1,145 A/R SUSPENSE-REFUNDS						
1,200	1,200 PREPAID	74,446					
1,220	1,220 OTHER PREPAID EXPENSES						
1,300	1,300 DIETARY INVENTORY						
1,310	1,310 SUPPLIES INVENTORY						
1,320	1,320 LINEN INVENTORY						
1,409	1,409 LAND	630,000					
1,450	1,450 FURNITU	1,725,749					
1,460		(1,525,590)					
1,475	1,475 CODE AI	6,878,870					
1,490	1,490 ACCUM I	(4,305,767)					
1,530	1,530 RESIDEN	22,123					
1,550	1,550 LOAN FE	0					
1,551	1,551 LOAN FEES ADDED						
1,850	1,850 INTERCC	1,618,582					
2,010	2,010 ACCOUN	(431,863)					
2,100	2,095 BONUSES PAYABLE						
2,100	2,100 ACCRUE	0					
2,100	2,100 PR CLEARING-BENEFITS						
2,100	2,100 PR CLEARING-LABOR						
2,110	2,110 ACCRUE	0					
2,120	2,120 U.C. TAXES PAYABLE						

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	0	0
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	-4,908	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-140,090	
2350	REAL ESTATE TAX PAYAB	-131,997	
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	-22,123	
2600	MORTGAGE PAYABLE	-1,544,105	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-5,045,686	
2970	PROFIT/LOSS FOR PERIOD	-922,530	
3007.1	PATIENT DAYS-PRIVATE	12,062	

2,125	2,125	FICA TA:	0
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	(4,908)
2,320	2,320	IPA PAYI	(140,090)
2,350	2,350	REAL ES	(131,997)
2,385			0
2,400	2,400	CURRENT PORTION OF LT DI	
2,512	2,512	DUE TO I	(22,123)
2,600	2,600	LASALLI	(1,544,105)
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	(5,045,686)
		net incom	(922,530)
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	33,669					3,007
3007.3		PATIENT DAYS-MEDICARE	10,196					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 &	-10,919,011	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	-114,925	0	0	0	0	3,081
3081	1	NURSING SUPPLIES-IPA		0	0	0	0	3,082
3082	1	NURSING SUPPLIES MED PT A		0	0	0	0	3,083
3083	1	NURSING SUPPLIES MED PT B						3,100
3100	17	DRUGS	-2,109,264	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-3,624,500	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	4,915,583	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	-26,665		0	0	0	0		3,560
3560		12	ACTIVITY FUND INCOME	-111		0	0	0	0		3,570
3570		12	VENDING INCOME/EXPENS	-2,127		0	0	0	0		3,590
3580		12	MANAGEMENT FEES			0	0	0	0		3,595
3590		1	EQUIPMENT RENTAL	-12,979		0	0	0	0		3,600
3595		21	RESIDENT TRANSPORTATI	2,180		0	0	0	0		4,110
3600		21	MISC INCOME	0		0	0	0	0		4,111
4110			GENERAL & ADMINIST WA	436,865	471,829	21	1	17	0		4,115
4111			ADMINISTRATOR WAGES	85,629	85,629	17	1	0	0		4,120
4115			VACATION & SICK - G&A	34,964		21	1	0	0		4,125
4120	4475		EMPLOYEE BENEFITS	19,999	1,101,125	22	3	0	0		4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0		4,135
4130			EMPLOYEE SCHOLORSHIP	4,635		21	1	0	0		4,250
4135			EMPLOYEE SCHOLORSHIP	3,188		23	3	0	0		4,255
4220			DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255		OFFICE SUPPLIES	45,638	45,638	21	2	0	0		4,275
4260			TELEPHONE	64,671	64,671	21	3	0	0		4,276
4275			TRAINING & EMPLOYEE D	11,076	11,076	23	3	16	0	**	4,280
4280			GENERAL TRAVEL	1,720	3,823	24	3	16	0		4,281
4281			MEAL EXPENSE FOR TRAV	31		24	3	19	0		4,285
4285			EDUCATION & SEMINAR	2,072		24	3	19	-14,303	***	4,289
4290			HELP WANTED ADVERTISI	12,708	141,159	20	3	0	0	-97,455	4,290
4291			PROMOTIONAL ADVERTIS	1,622		20	3	25	-1,622		4,291
4292			PUBLIC RELATIONS	10,522		20	3	25	-10,522		4,292
4300			LICENSES & FEES	98,679		20	3	17	0		4,300
4310			DUES & SUBSCRIPTIONS	12,498		20	3	17	-1,274		4,310
4320			CONTRIBUTIONS	200		27	3	20	0		4,320
4350			PROFESSIONAL FEES	38,616	443,332	19	3	22	-18,401		4,350
4355			MEDICAL DIRECTOR	16,650	16,650	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	840		10	3	0	0		4,364
4363	PHARMACIST FEES	10,680		10	3	0	0		4,370
4364	SOC SERV/ACT CONSULT	3,113	3,113	12	3	0	0		4,383
4370	TV RENTAL	4,293		35	3	5	0		4,390
4380	INCOME TAXES		30,618	27	3	26	0		4,400
4383	BACKGROUND CHECKS	5,130		20	3	26	0		4,401
4400	PAYROLL TAXES	480,731		22	3	0	0		4,410
4401	PAYROLL TAXES ADMINIS	8,888		22	3	0	0		4,420
4410	GROUP INSURANCE	451,957		22	3	0	0		4,430
4420	LIABILITY INSURANCE	211,503	211,503	26	3	0	0		4,435
4425	INSURANCE-OWNERS			22	3	21	0		4,436
4430	WORKMENS COMP INSURA	131,727		22	3	0	0		4,450
4450	CENTRAL OFFICE FEES	404,716		19	3	34	0	**	4,460
4460	BAD DEBTS	30,000		27	3	24	-30,000		4,461
4470	LOST ITEMS-RESIDENTS	418		27	3	0			4,470
4490	MISCELLANEOUS	0		27	3	0	0		4,475
4510	REAL ESTATE TAXES	120,054	120,054	33	3	0	0		4,486
4600	LEASED EQUIPMENT	9,433	13,726	35	3	16	0		4,490
5110	MAINTENANCE SALARIES	136,618	147,175	6	1	0	0		4,496
5120	MAINTENANCE SICK & VA	10,557		6	1	0	0		4,510
5130	ELECTRIC	136,561	222,982	5	3	0	0		4,600
5131	NATURAL GAS	39,142		5	3	0	0		5,110
5132	HEATING & DEISEL OIL			5	3	0	0		5,120
5133	WATER & SEWER	47,279		5	3	0	0		5,130
5134	TRASH COLLECTION	40,798	114,423	6	3	0	0		5,131
5140	PROPERTY PLANT REPLAC	24,489	81,613	6	2	0	0		5,133
5160	GENERAL REPAIR & MAIN	57,124		6	2	0	0		5,134
5165	MAINTENANCE CONTRAC	73,625		6	3	0	0		5,140
5210	DIETARY WAGES	344,550	364,328	1	1	0	0		5,160
5220	DIETARY SICK & VAC	19,778		1	1	0	0		5,165
5240	SALES TAX			2	3	13	0		5,210
5248	FOOD PURCHASES	381,860	377,874	2	2	0	0		5,220
5250	SUPPLIES-DISHWASHING	5,664	26,778	1	2	0	0		5,248

5260	DIETARY REPLACEMENT	6,189		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	14,925		1	2	0	0	5,260
5295	MEAL CREDIT	-3,986		2	2	0	0	5,270
5310	LAUNDRY WAGES	105,152	111,649	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	6,497		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	15,197	26,574	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	11,377		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	195,592	210,629	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	15,037		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	27,883	61,029	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	33,146		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		3,472,668	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	476,406		10	1	0	0	6,020
6030	DON WAGES	70,489		10	1	0	0	6,030
6035	ADON	176,581		10	1	0	0	6,035
6040	RN SICK & VACATION	40,819		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	985,900		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	61,364		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC	1,562,997		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	91,440		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	6,672		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0		7,280
6290	NURSING SUPPLIES	42,913	302,359	10	2	0	0		7,281
6295	NURSING SUPPLIES	242,885		10	2	0	0		7,380
6390	REPLACEMENT-NURSING	16,561		10	2	0	0		7,391
6490	NURSING OTHER	9,548	21,068	10	3	0	0		7,393
7280	DRUG PURCHASES	703,532	1,150,013	39	2	0	0	***	7,510
7281	DRUG PURCHASES-OTHER	445,966		39	2				7,540
7380	LABORATORY SERVICES	49,894	1,010,999	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	99,335	108,762	11	1	0	0		7,720
7540	ACTIVITIES SICK & VAC	9,427		11	1	0	0		7,730
7590	ACTIVITIES SUPPLIES	3,674	3,674	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	458,263		39	3	0	0	***	7,890
7660	PT SUPPLIES	515		39	2	0	0		7,960
7710	SOCIAL SERVICE WAGES	60,640	65,284	12	1	0	0		8,120
7720	SOCIAL SERVICE SICK & V	4,644		12	1	0	0		8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0		8,130
7740	OT FEE	416,652		39	3	0	0	***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510
7770	SPEECH THERAPY FEE	86,190		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	21,889	21,889	40	3	0	0		
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910	VOLUNTEER COORDINATOR			21	1	0	0		
7940	VOL COORD SICK & VAC			21	1	0	0		
7960	VOL COORD SUPPLIES	0		21	2	0	0		
8100	RENT	0	0	34	3	0	0		

8120	INTEREST EXPENSE	70,225	70,225	32	3	14	-78,618	
8130	DEPRECIATION	309,801	309,801	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-78,618		32	0	10	0	
9520	MISC NON-OPERATING INC	446		0	0	0	0	
9700	INCOME TAXES	1,719		0	0	0	0	
		10,969,289	11,045,742					
			76,453					
GRAND TOTALS		-922,530					-154,740	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	12,062	12,062
IPA	33,669	33,669
medicare	10,196	10,196
		55,927

IPA BEDHOLDS 0
PP BEDHOLDS 0
PP CONVERS 0

LES

E

FUND

ERIA

EBT

EBT

3,007 PATIENT 12,062

3,007	PATIENT	33,669
3,007	PATIENT	10,196
		0
3,010	BASIC CH	(10,919,011)
3,020	BASIC CH	0
3,030	BASIC CH	0
		0
		0
		0
		0
3,080	NURSING	(114,925)
3,081	NURSING	0
3,082	NURSING	0
3,083	NURSING	0
3,100	DRUGS-M	(2,109,264)
		0
3,110	PHYSICAL	(3,624,500)
		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	4,757,823

3,520	RENT INC	0
3,530	BEAUTY S	(26,665)
		(111)
3,570	VENDING	(2,127)
3,590	EQUIPME	(12,979)
3,595	RESIDENT	2,180
3,600	MISC INC	0
4,110	G&A WAG	436,865
4,111	ADMINIST	85,629
4,115	G&A PTO	34,964
4,120	EMPLOYE	15,594
4,130	EMPLOYE	4,635
4,135	EMPLOYE	3,188
4,250	OFFICE SU	28,601
4,255	POSTAGE	5,385
4,260	TELEPHO	64,671
4,275	TRAININ(	11,076
		(6)
4,280	GENERAI	1,720
4,281	MEAL EX	31
4,285	EDUCATI	1,995
4,289	MEETING	77
4,290	HELP WA	12,708
4,291	PROMOTI	1,622
4,292	PUBLIC R	10,522
4,300	LICENSE	98,679
4,310	DUES & S	12,498
4,320	CONTRIB	200
4,350	PROFESSI	38,616
4,355	MEDICAL	16,650
		840
		10,680

4,364	SOCIAL S	3,113
4,370	TV RENT/	4,293
4,383	BACKGR(	5,130
4,390	OTHER T/	1,719
4,400	PAYROLL	480,731
4,401	PAYROLL	8,888
4,410	GROUP IN	451,957
4,420	LIABILIT'	211,503
4,430	WORKMA	124,944
4,435	W/C-FIRS'	789
4,436	DRUG TE:	6,000
4,450	MANAGE	404,716
4,460	BAD DEB'	30,000
4,461	BAD DEB'	157,760
4,470	LOST ITE:	418
4,475	UNIFORM	4,405
4,486	SERVICE	33,733
4,490	MISC EXP	1,402
4,496	MISC. M.I	11,652
4,510	REAL EST	120,054
4,600	LEASED E	9,433
5,110	MAINTEN	136,618
5,120	MAINTEN	10,557
5,130	ELECTRI(	136,561
5,131	NATURAL	39,142
5,133	WATER &	47,279
5,134	TRASH C(	40,798
5,140	PROP/PLA	24,489
5,160	GENERAL	57,124
5,165	MAINTEN	39,892
5,210	DIETARY	344,550
5,220	DIETARY	19,778
5,248	FOOD PU	380,458

5,250	SUPPLIES	5,664
5,260	REPLACE	6,189
5,270	KITCHEN	14,925
5,295	MEAL IN(	(3,986)
5,310	LAUNDR'	105,152
5,340	LAUNDR'	6,497
5,370	REPLACE	15,197
		0
5,390	SUPPLIES	11,377
5,410	HOUSEKE	195,592
5,440	HOUSEKE	15,037
5,480	SUPPLIES	27,883
5,490	SUPPLIES	33,146
6,020	RN WAGE	476,406
6,030	DON WA(	70,489
6,035	ADON W/	176,581
6,040	RN PTO &	40,819
6,120	LPN WAG	985,900
6,140	LPN PTO	61,364
6,220	AIDES W/	1,562,997
6,240	AIDES PT	91,440
		0
		0
		0
6,270	REHAB W	6,672
6,275	REHAB P'	0
6,290	NURSING	42,913
6,295	NURSING	242,885
6,390	REPLACE	16,561
6,490	OTHER	9,548

7,280	DRUG PU	703,532
7,281	DRUG PU	445,966
7,380	LABORAT	22,710
7,390	X-RAY SE	3,132
		24,052
7,510	ACTIVITI	99,335
7,540	ACTIVITI	9,427
7,590	ACTIVITI	3,674
7,620	PHYSICA	458,263
7,660	P.T. SUPP	515
7,710	SOCIAL S	60,640
7,720	SOCIAL S	4,644
7,730	SOCIAL S	0
7,740	OCCUPAT	416,652
7,770	SPEECH T	86,190
7,820	BEAUTIC	21,889
		0
		0
8,120	INTEREST	70,225
		0
8,130	DEPRECI	309,801
		0
9,510	INTEREST	(78,618)
9,520	MISC NO	0
4,220		0
8,100		0
9,702		446
5,230		0
		(922,530)

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