FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0050930

Facility Name: Illini Heritage Rehab & HC

Address: 1315 Curt Dr Bx 6179 (Number) Champaign (City) 61820 (Zip Code)

County: Champaign

Telephone Number: (217) 352-5707 **Fax #** (217)352-2607

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1996

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 689-5850
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 1/1/2013 to 12/31/2013 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) Mark B. Petersen
(Title) Chief Executive Officer

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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 N/A

	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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	15,869	3,713	314	19,896	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,869	3,713	314	19,896	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.85%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X] NO [ ]

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 12/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 302

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,828	12,129		150,957		150,957	3,921	154,878			1
2	Food Purchase		118,658		118,658		118,658	(1,817)	116,841			2
3	Housekeeping	103,991	29,500		133,491		133,491	39	133,530			3
4	Laundry	27,502	11,816		39,318		39,318		39,318			4
5	Heat and Other Utilities			75,775	75,775		75,775	297	76,072			5
6	Maintenance	23,508	9,772	21,521	54,801		54,801	1,920	56,721			6
7	Other (specify):* Home Off. Ben. All.							222	222			7
8	**TOTAL General Services**	293,829	181,875	97,296	573,000		573,000	4,582	577,582			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	916,703	82,788	5,843	1,005,334		1,005,334	14	1,005,348			10
10a	Therapy			123,228	123,228		123,228		123,228			10a
11	Activities	40,000	132	119	40,251		40,251	(4,511)	35,740			11
12	Social Services	27,276			27,276		27,276		27,276			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	983,979	82,920	141,190	1,208,089		1,208,089	(4,497)	1,203,592			16
	C. General Administration											
17	Administrative			150,000	150,000		150,000	(82,000)	68,000			17
18	Directors Fees											18
19	Professional Services			9,767	9,767		9,767	8,266	18,033			19
20	Dues, Fees, Subscriptions & Promotions			4,598	4,598		4,598	526	5,124			20
21	Clerical & General Office Expenses	26,962	3,981	21,064	52,007		52,007	48,833	100,840			21
22	Employee Benefits & Payroll Taxes			181,840	181,840		181,840		181,840			22
23	Inservice Training & Education			611	611		611	78	689			23
24	Travel and Seminar							4	4			24
25	Other Admin. Staff Transportation			6,385	6,385		6,385	3,629	10,014			25
26	Insurance-Prop.Liab.Malpractice			21,886	21,886		21,886	28,951	50,837			26
27	Other (specify):* Home Off. Ben. All.							4,497	4,497			27
28	**TOTAL General Administration**	26,962	3,981	396,151	427,094		427,094	12,784	439,878			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,304,770	268,776	634,637	2,208,183		2,208,183	12,869	2,221,052			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 Illini Heritage Rehab & HC #0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			15,723	15,723		15,723	49,183	64,906			30
31	Amortization of Pre-Op. & Org.							5,268	5,268			31
32	Interest			9,614	9,614		9,614	84,747	94,361			32
33	Real Estate Taxes							29,736	29,736			33
34	Rent-Facility & Grounds			197,935	197,935		197,935	(197,935)				34
35	Rent-Equipment & Vehicles			30,345	30,345		30,345	580	30,925			35
36	Other (specify):*											36
37	**TOTAL Ownership**			253,617	253,617		253,617	(28,421)	225,196			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,035		15,035		15,035		15,035			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,318	151,318		151,318		151,318			42
43	Other (specify):* Non-allowable Costs		239	89,123	89,362		89,362	(89,362)				43
44	**TOTAL Special Cost Centers**		15,274	240,441	255,715		255,715	(89,362)	166,353			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,304,770	284,050	1,128,695	2,717,515		2,717,515	(104,914)	2,612,601			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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	(1,901)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,410)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,562	30		9
10	Interest and Other Investment Income	(9,946)	32		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				17
18	Fines and Penalties	(26,655)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,311)	43		24
25	Fund Raising, Advertising and Promotional	(2,090)	43		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 See Page 5A	(8,162)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (103,913)		$	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)	(1,001)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,001)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (104,914)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Illini Heritage Rehab & HC

ID# 0050930

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,315)	43	1
2	X-Rays-Part A	(1,110)	43	2
3	Miscellaneous Revenue Offset of Office Supplies	245	21	3
4	Resident Flowers	(536)	43	4
5	Special Events	65	43	5
6	Miscellaneous Revenue Offset of Transportation Rev.	(4,511)	11	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(8,162)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Heritage Rehab & HC **#** 0050930 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	3,921	0	0	0	0	0	0	0	0	0	3,921	1
2	Food Purchase	(1,901)	84	0	0	0	0	0	0	0	0	0	(1,817)	2
3	Housekeeping	0	39	0	0	0	0	0	0	0	0	0	39	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	297	0	0	0	0	0	0	0	0	0	297	5
6	Maintenance	0	1,920	0	0	0	0	0	0	0	0	0	1,920	6
7	Other (specify):*	0	222	0	0	0	0	0	0	0	0	0	222	7
8	**TOTAL General Services**	(1,901)	6,483	0	0	0	0	0	0	0	0	0	4,582	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	14	0	0	0	0	0	0	0	0	0	14	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,511)	0	0	0	0	0	0	0	0	0	0	(4,511)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	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**	(4,511)	14	0	0	0	0	0	0	0	0	0	(4,497)	16
	C. General Administration													
17	Administrative	0	(82,000)	0	0	0	0	0	0	0	0	0	(82,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,266	0	0	0	0	0	0	0	0	0	8,266	19
20	Fees, Subscriptions & Promotions	0	0	526	0	0	0	0	0	0	0	0	526	20
21	Clerical & General Office Expenses	245	0	48,588	0	0	0	0	0	0	0	0	48,833	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	78	0	0	0	0	0	0	0	0	78	23
24	Travel and Seminar	0	0	4	0	0	0	0	0	0	0	0	4	24
25	Other Admin. Staff Transportation	0	0	3,629	0	0	0	0	0	0	0	0	3,629	25
26	Insurance-Prop.Liab.Malpractice	0	0	701	28,250	0	0	0	0	0	0	0	28,951	26
27	Other (specify):*	0	0	4,497	0	0	0	0	0	0	0	0	4,497	27
28	**TOTAL General Administration**	245	(73,734)	58,023	28,250	0	0	0	0	0	0	0	12,784	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,167)	(67,237)	58,023	28,250	0	0	0	0	0	0	0	12,869	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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	1,562	0	3,221	44,400	0	0	0	0	0	0	0	49,183	30
31	Amortization of Pre-Op. & Org.	0	0	0	5,268	0	0	0	0	0	0	0	5,268	31
32	Interest	(9,946)	0	5,358	89,335	0	0	0	0	0	0	0	84,747	32
33	Real Estate Taxes	0	0	315	29,421	0	0	0	0	0	0	0	29,736	33
34	Rent-Facility & Grounds	0	0	0	(197,935)	0	0	0	0	0	0	0	(197,935)	34
35	Rent-Equipment & Vehicles	0	0	580	0	0	0	0	0	0	0	0	580	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,384)	0	9,474	(29,511)	0	0	0	0	0	0	0	(28,421)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(89,362)	0	0	0	0	0	0	0	0	0	0	(89,362)	43
44	**TOTAL Special Cost Centers**	(89,362)	0	0	0	0	0	0	0	0	0	0	(89,362)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(103,913)	(67,237)	67,497	(1,261)	0	0	0	0	0	0	0	(104,914)	45

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,921	$ 3,921	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	84	84	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	39	39	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	297	297	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,920	1,920	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	222	222	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	14	14	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	150,000	Petersen Health Care, Inc.	100.00%	68,000	(82,000)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	8,266	8,266	12
13	V								13
14	Total			$ 150,000			$ 82,763	$ * (67,237)	14

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

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 526	$ 526	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	48,588	48,588	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	78	78	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	4	4	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,629	3,629	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	701	701	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,497	4,497	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,221	3,221	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,358	5,358	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	315	315	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	580	580	26
27	V								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			$			$ 67,497	$ * 67,497	39

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

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	20	Dues, Fees and Subscriptions	$	Heritage Nursing Center, LLC	100.00%	$ 0	$	15
16	V	26	Property Insurance	$	Heritage Nursing Center, LLC	100.00%	21,153	21,153	16
17	V	26	Mortgage Insurance		Heritage Nursing Center, LLC	100.00%	7,097	7,097	17
18	V	30	Depreciation		Heritage Nursing Center, LLC	100.00%	44,400	44,400	18
19	V	31	Amortization		Heritage Nursing Center, LLC	100.00%	5,268	5,268	19
20	V	32	Interest		Heritage Nursing Center, LLC	100.00%	89,335	89,335	20
21	V	33	Real Estate Taxes		Heritage Nursing Center, LLC	100.00%	29,421	29,421	21
22	V	34	Rent-Facility & Grounds	197,935	Heritage Nursing Center, LLC	100.00%	0	(197,935)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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			$ 197,935			$ 196,674	$ * (1,261)	39

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

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Aledo Health Care Center	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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									$		1
2											2
3											3
4	N/A										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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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: Petersen Health Care, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	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	Resident Days	1,560,986	75	$ 307,592	$ 295,212	0	$ 3,921	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	0	84	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	0	39	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	0	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	0	297	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	0	1,920	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	0	222	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	0	14	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	0	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	0	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	0	68,000	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	0	8,266	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	0	526	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	0	48,588	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	0	78	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	0	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	0	3,629	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	0	701	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	0	4,497	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	0	3,221	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	0	5,358	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	0	315	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	0	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	0	580	24
25	TOTALS					$ 11,032,372	$ 8,354,323		$ 150,260	25

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	Capmark		X	Mortgage	$9,536.20	08/01/02	$ 1,615,000	$ 1,408,004	9/1/37	0.0630	$ 98,949	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$9,536.20		$ 1,615,000	$ 1,408,004			$ 98,949	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(9,946)	11
12								Home Office Allocation-PHC			5,358	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,588)	14
15	TOTALS (line 9+line14)						$ 1,615,000	$ 1,408,004			$ 94,361	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 7,097 **Line #** 26

*** 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 Illini Heritage Rehab & HC # 0050930 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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.**	$ 29,000	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.)	2012	$ 28,421	2
3. Under or (over) accrual (line 2 minus line 1).		$ (579)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,000	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. **Home Office Allocation** 315 **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.		$ 29,736	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	26,445	8
	2009	26,532	9
	2010	26,987	10
	2011	27,227	11
	2012	28,421	12

Accrual based on prior year tax bill.

	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 Illini Heritage Rehab & HC COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0050930

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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.	41-20-02-132-008	Long-Term Care Facility	$ 28,420.78	$ 28,420.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,420.78	$ 28,420.78

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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,312 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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. [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).

N/A

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

1. Total Amount Incurred: 184,186 2. Number of Years Over Which it is Being Amortized: 35

3. Current Period Amortization: 5,268 4. Dates Incurred: 2013

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	Facility		1996	$ 41,400	1
2					2
3	TOTALS			$ 41,400	3

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	60		1996	1974	$ 979,800	$	27.5	$ 35,629	$ 35,629	$ 605,693	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Paving			1997	16,431		39	421	421	6,894	9
10	Water Heater			1997	4,300		39	110	110	1,856	10
11	Laundry Repair			1997	1,633		39	42	42	698	11
12	Remodeling			1997	33,803		39	867	867	14,341	12
13	Remodeling			1997	22,305		27.5	811	811	13,348	13
14	Paving			1998	2,900		39	74	74	1,156	14
15	Tiling			1999	38,000		27.5	1,382	1,382	20,096	15
16	Garden			1999	35,912		27.5	1,306	1,306	18,991	16
17	Birdhouse			1999	4,043		27.5	147	147	2,076	17
18	Tuckpointing			1999	36,200		27.5	1,316	1,316	19,027	18
19	Windows			1999	49,227		27.5	1,790	1,790	25,433	19
20	Parking Lot Paving			1999	5,900		27.5	215	215	3,054	20
21	Shed			1999	12,000		27.5	436	436	6,304	21
22	Steam Table			1999	3,000		27.5	109	109	1,576	22
23	Windows			2000	30,922		27.5	1,124	1,124	15,690	23
24	Roof Repair			2003	4,160		39	107	107	1,119	24
25	Blinds			2007	4,571		10	457	457	2,971	25
26	Water Heaters			2007	11,705		15	780	780	5,070	26
27	New Roof			2007	30,000		20	1,500	1,500	9,750	27
28	Windows			2008	16,695		20	834	834	4,587	28
29	2nd Installment of 2007 Roof			2008	57,945		20	2,898	2,898	15,939	29
30	Door			2008	2,793		15	186	186	1,023	30
31	Blinds			2008	3,481		10	348	348	1,914	31
32	Parking Lot Repair			2011	5,816		7	830	830	2,075	32
33	Door Replacement			2013	2,911		7	208	208	208	33
34											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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	Building Improvement Booked			6,346			(6,346)		65
66									66
67	2013-Home Office Allocation-Building Improvements		9,355			224	224		67
68	2013-Home Office Allocation-Land Improvements		873			56	56		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,426,681	$ 6,346		$ 54,207	$ 47,861	$ 800,889	70

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

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	$ 41,890	$ 5,499	$ 4,189	$ (1,310)	5-10 yrs.	$ 16,657	71
72	Current Year Purchases	6,845	652	343	(309)	10 yrs.	343	72
73	Fully Depreciated Assets	404,926					404,926	73
74	Home Office Allocation			2,941	2,941			74
75	TOTALS	$ 453,661	$ 6,151	$ 7,473	$ 1,322		$ 421,926	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	Facility	Van	2012	$ 16,131	$ 3,226	$ 3,226	$	5 yrs.	$ 4,839	76
77										77
78										78
79										79
80	TOTALS			$ 16,131	$ 3,226	$ 3,226	$		$ 4,839	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)	$ 1,937,873	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,723	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,906	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 49,183	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,227,654	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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 ☒ X NO
16. Rental Amount for movable equipment: $ 30,925 Description: See Attached Schedule 14A
    (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	N/A				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.

Illini Heritage Rehab & HC
0050930
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 27,335
Dishwasher	654
Laundry Equipment	-
Copier	2,356
Home Office Allocation	580
	30,925

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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
   - [X] 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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	10A(3)	hrs	$	3,486	$ 52,291	$	3,486	$ 52,291	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,317	19,751		1,317	19,751	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,404	51,063		3,404	51,063	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				15,035		15,035	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			8	123		8	123	13
14	TOTAL			$	8,215	$ 123,228	$ 15,035	8,215	$ 138,263	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.

STATE OF ILLINOIS

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 15,207	$ 15,407	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 79,733)	487,803	487,803	3
4	Supply Inventory (priced at)	9,085	9,085	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,900	28,749	6
7	Other Prepaid Expenses	36,336	36,336	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	350	350	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 568,681	$ 577,730	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		41,400	13
14	Buildings, at Historical Cost		989,155	14
15	Leasehold Improvements, at Historical Cost	135,916	437,526	15
16	Equipment, at Historical Cost	64,866	469,792	16
17	Accumulated Depreciation (book methods)	(77,834)	(1,227,654)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		124,503	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): RE Entity Escrow Reserves		344,687	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 122,948	$ 1,179,409	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 691,629	$ 1,757,139	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 612,298	$ 612,298	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,428	80,428	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,757	11,757	31
32	Accrued Real Estate Taxes(Sch.IX-B)		30,000	32
33	Accrued Interest Payable		7,392	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	8,731	8,731	36
37	Accrued Management Fees	271,885	271,885	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 985,099	$ 1,022,491	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,408,004	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,062,481	1,171,026	43
44	Deferred Rent	102,151	541,512	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,164,632	$ 3,120,542	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,149,731	$ 4,143,033	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,458,102)	$ (2,385,894)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 691,629	$ 1,757,139	48

*(See instructions.)

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,251,688)	1	
2	Restatements (describe):		2	
3	**Rounding**		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,251,688)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(158,277)	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	(48,137)	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)**	$ (206,414)	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)**	$ (1,458,102)	24	*

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

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	$ 2,393,932	1
2	Discounts and Allowances for all Levels	(75,003)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,318,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	194,581	6
7	Oxygen	140	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 194,721	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,901	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,065	20
21	Other Medical Services	310	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 31,376	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,946	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,946	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	(245)	28
28a	Transportation Revenue	4,511	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,266	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,559,238	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	573,000	31
32	Health Care	1,208,089	32
33	General Administration	427,094	33
	B. Capital Expense		
34	Ownership	253,617	34
	C. Ancillary Expense		
35	Special Cost Centers	104,397	35
36	Provider Participation Fee	151,318	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,717,515	40
41	**Income before Income Taxes (line 30 minus line 40)****	(158,277)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (158,277)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,832,027	44
45	Private Pay - Net Inpatient Revenue	448,525	45
46	Medicare - Net Inpatient Revenue	40,676	46
47	Other-(specify) Charity Therapy Allowance	(2,299)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,318,929	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 Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	2,003	2,003	$ 62,583	$ 31.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,889	3,938	102,752	26.09	3
4	Licensed Practical Nurses	12,524	12,946	298,303	23.04	4
5	CNAs & Orderlies	38,623	39,402	406,248	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	549	557	7,154	12.84	9
10	Activity Assistants	1,268	1,311	15,167	11.57	10
11	Social Service Workers	2,080	2,080	27,276	13.11	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	39,150	18.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,156	10,618	99,678	9.39	15
16	Dishwashers					16
17	Maintenance Workers	1,560	1,619	23,508	14.52	17
18	Housekeepers	10,494	10,953	103,991	9.49	18
19	Laundry	3,038	3,076	27,502	8.94	19
20	Administrator	2,080	2,080	68,000	32.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,813	1,971	26,962	13.68	23
24	Clerical					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 C: CPC	1,853	1,905	46,817	24.58	32
33	Other(specify) Transportation	1,568	1,641	17,679	10.77	33
34	TOTAL (lines 1 - 33)	95,578	98,180	$ 1,372,770 *	$ 13.98	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		$		35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,965	L10, C3	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,965		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chris Collins	Administrator	0	$ 68,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 150,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 150,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Comcast Cable	Computer Services	$ 2,888
Champaign Co. Circuit Clerk	Filing Fees	103
Ginoli & Company	Accounting Services	3,995
Honkamp Krueger & Co.	Collection Fees	2,781
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 9,767

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,983
Unemployment Compensation Insurance	74,069
FICA Taxes	98,544
Employee Health Insurance	(19,681)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,925
TOTAL (agree to Schedule V, line 22, col.8)	$ 181,840

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	971
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 92	929
Miscellaneous Licenses & Permits	708
Miscellaneous Dues & Subscriptions	0
Home Office Allocation	526
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,124

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	4
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4

**See instructions.

Illini Heritage Rehab & HC
0050930
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,767
Home Office Allocation		
SmithAmundsen	Legal	491
Cole, Schotz, Meisel	Legal	271
Black, Hedin, Ballard	Legal	24
Ginoli & Company	Accountants	895
Miscellaneous	Computer Services	77
Odessian LLC	Computer Services	39
CCH	Computer Services	11
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	10
Macquarie Technology Services	Computer Services	70
Advanced Answers on Demand	Computer Services	3638
TeamViewer	Computer Services	12
Stratus Networks	Computer Services	293
Kemper Technology	Computer Services	227
AT&T	Computer Services	4
Medifax	Computer Services	33
Vision Share/Ability Network	Computer Services	498
Barracuda	Computer Services	90
CIAN	Computer Services	120
Comcast	Computer Services	27
Emdeon	Computer Services	40
Marotta Gund Budd & Dzera	Other Prof Fees	1113
David Budde	Other Prof Fees	23
Pharmacy Price Mangement	Other Prof Fees	92
All Scripts	Other Prof Fees	164

Total (agree to Schedule V, line 19, column 8)	18,033

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Illini Heritage Rehab & HC # 0050930 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **N/A**

(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? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,717** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **151,318**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,901**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,511**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company**

(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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Illini Heritage Rehab &** **09:44 AM** **5/21/2014**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-104,914	equal to	-104,914	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	94,361	equal to	94,361	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	29,736	equal to	29,736	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	5,268	equal to	5,268	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	64,906	equal to	64,906	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	30,925	equal to	30,925	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	123,228	equal to	123,228	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	15,035	equal to	15,035	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	573,000	equal to	573,000	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,208,089	equal to	1,208,089	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	427,094	equal to	427,094	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	253,617	equal to	253,617	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	104,397	equal to	104,397	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	151,318	equal to	151,318	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	916,703	equal to	916,703	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	40,000	equal to	40,000	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	27,276	equal to	27,276	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	138,828	equal to	138,828	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	23,508	equal to	23,508	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	103,991	equal to	103,991	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	27,502	equal to	27,502	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	68,000	equal to	68,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	26,962	equal to	26,962	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,372,770	equal to	1,304,770	68,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,965	< or = to	5,843	-1,878	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	119	-119	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	68,000	equal to	68,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	150,000	equal to	150,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	9,767	equal to	9,767	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	181,840	equal to	181,840	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,124	equal to	5,124	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4	equal to	4	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	151,318	equal to	151,318	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	302	equal to	314	-12	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-1,001	equal to	-1,001	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,408,004	equal to	1,408,004	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	30,000	equal to	30,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	41,400	equal to	41,400	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,426,681	equal to	1,426,681	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	469,792	equal to	469,792	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,227,654	equal to	1,227,654	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,458,102	equal to	-1,458,102	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-158,277	equal to	-158,277	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	691,629	equal to	691,629	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	138,828	12,129	0	150,957	0	150,957	3,921	154,878
2. Food Purchase	0	118,658	0	118,658	0	118,658	-1,817	116,841
3. Housekeeping	103,991	29,500	0	133,491	0	133,491	39	133,530
4. Laundry	27,502	11,816	0	39,318	0	39,318	0	39,318
5. Heat and Other Utilities	0	0	75,775	75,775	0	75,775	297	76,072
6. Maintenance	23,508	9,772	21,521	54,801	0	54,801	1,920	56,721
7. Other (specify)*	0	0	0	0	0	0	222	222
8. Total General Services	293,829	181,875	97,296	573,000	0	573,000	4,582	577,582
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	916,703	82,788	5,843	1,005,334	0	1,005,334	14	1,005,348
10a. Therapy	0	0	123,228	123,228	0	123,228	0	123,228
11. Activities	40,000	132	119	40,251	0	40,251	-4,511	35,740
12. Social Services	27,276	0	0	27,276	0	27,276	0	27,276
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	983,979	82,920	141,190	1,208,089	0	1,208,089	-4,497	1,203,592
17. Administrative	0	0	150,000	150,000	0	150,000	-82,000	68,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,767	9,767	0	9,767	8,266	18,033
20. Fees, Subscriptions & Promotion	0	0	4,598	4,598	0	4,598	526	5,124
21. Clerical & General Office	26,962	3,981	21,064	52,007	0	52,007	48,833	100,840
22. Employee Benefits & Payroll	0	0	181,840	181,840	0	181,840	0	181,840
23. Inservice Training & Education	0	0	611	611	0	611	78	689
24. Travel and Seminar	0	0	0	0	0	0	4	4
25. Other Admin. Staff Trans	0	0	6,385	6,385	0	6,385	3,629	10,014
26. Insurance-Prop.Liab.Malpractice	0	0	21,886	21,886	0	21,886	28,951	50,837
27. Other (specify)*	0	0	0	0	0	0	4,497	4,497
28. Total General Adminis	26,962	3,981	396,151	427,094	0	427,094	12,784	439,878
29. Total General Administrative	1,304,770	268,776	634,637	2,208,183	0	2,208,183	12,869	2,221,052
30. Depreciation	0	0	15,723	15,723	0	15,723	49,183	64,906
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	5,268	5,268
32. Interest	0	0	9,614	9,614	0	9,614	84,747	94,361
33. Real Estate	0	0	0	0	0	0	29,736	29,736

34. Rent - Facility & Grounds		0	0	197,935	197,935	0	197,935	-197,935	0
35. Rent - Equipment & Vehicles		0	0	30,345	30,345	0	30,345	580	30,925
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	253,617	253,617	0	253,617	-28,421	225,196
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	15,035	0	15,035	0	15,035	0	15,035
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	151,318	151,318	0	151,318	0	151,318
43. Other (specify):*		0	239	89,123	89,362	0	89,362	-89,362	0
44. Total Special Cost Ce		0	15,274	240,441	255,715	0	255,715	-89,362	166,353
45. Grand Total		1,304,770	284,050	1,128,695	2,717,515	0	2,717,515	-104,914	2,612,601

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	15,207	15,407
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	487,803	487,803
4. Supply Inventory	9,085	9,085
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,900	28,749
7. Other Prepaid Expenses	36,336	36,336
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	350	350
10. Total current assets	568,681	577,730
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	41,400
14. Buildings, at Historical Cost	0	989,155
15. Leasehold Improvements, Historical Cost	135,916	437,526
16. Equipment, at Historical Cost	64,866	469,792
17. Accumulated Depreciation (book methods)	-77,834	-1,227,654
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	124,503
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	344,687
24. Total Long-Term Assets	122,948	1,179,409
25. Total Assets	691,629	1,757,139
CURRENT LIABILITIES		
26. Accounts Payable	612,298	612,298
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	80,428	80,428
31. Accrued Taxes Payable	11,757	11,757
32. Accrued Real Estate Taxes	0	30,000
33. Accrued Interest Payable	0	7,392
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	8,731	8,731

37. Other Current Liabilities (specify):	271,885	271,885
38. Total Current Liabilities	985,099	1,022,491
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	1,408,004
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,062,481	1,171,026
44.Other Long-Term Liabilities (specify):	102,151	541,512
45.Total Long-Term Liabilities	1,164,632	3,120,542
46.Total Liabilities	2,149,731	4,143,033
47.Total Equity	-1,458,102	-2,385,894
48.Total Liabilities and Equity	691,629	1,757,139

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,393,932
2. Discounts and Allowances for all Levels	-75,003
Subtotal - Inpatient Care	2,318,929
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	194,581
7. Oxygen	140
Subtotal - Anciliary Revenue	194,721
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,901
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	27,100
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	2,065
21. Other Medical Services	310
22. Laundry	0
Subtotal - Other Operating Revenue	31,376
24. Contributions	0
25. Interest and Other Investments Income	9,946
Subtotal - Non-Operating Revenue	9,946
27. Other Revenue (specify):	0
28. Other Revenue (specify):	4,266
Subtotal - Other Revenue	4,266
30. Total Revenue	2,559,238
31. General Services	572,325
32. Health Care	1,362,432
33. General Administration	455,245
34. Ownership	230,547

35.	Special Cost Centers	161,650
35.	Provider Participation Fee	207,677
37.	Other	0
40.	Total Expenses	2,989,876
41.	Income Before Income Taxes	-430,638
42.	Income Taxes	0
43.	Net Income or Loss for the Year	-430,638

Enter Cost Center Expenses **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 5/21/2014 09:44:03 AM

HSA Number: 4 Name: **Illini Heritage Rehab & HC**

Cost report period From: 1/1/2013 To: 12/31/2013 Base Number: 456

If this is an ICF/DD 16 facility, enter a 1 in cell C6 N

Licensed bed days: 21,900 Occupancy: 19,896 Pct. of occupancy: 90.85%

Illinois Public Aid Support Rate: $

Genl Services Salary/Wage:	293,829	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage:	26,962	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage:	1,304,770	Col 1, Line 44 ---Audit Adj:	
Employee Benefits:	181,840	Col 8, Line 22 ---Audit Adj:	
Total General Services:	577,582	Col 8, Line 8 ---Audit Adj:	
Total General Admin:	439,878	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month =	13	divided by 2 =
Beginning Day + Ending Day =	32	divided by 60.8 =
Beginning Year + Ending Year =	226	multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

$293,829
$1,304,770
22.5196%
$181,840

$40,950
$577,582
$618,532

$26,962
$1,304,770
2.0664%

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

	$181,840
	$3,758
	$439,878
	$181,840
	$261,796
	6.5
	0.526315789
	1356
	1363.026316
	907.00
	456
	1
	1
	$618,532
	1
	$618,532

$261,796	
1	
	$261,796
	$880,328
$43.90	
$880,328	
19,896	
$44.25	
21,900	
0.93	
20,367	
19,896	
471	
157	
19,896	
20,053	

$880,328
20053

$43.90

$47.44
$43.90

$3.54

0.5

$1.77

$43.90

45.67

$47.44
$43.90

$3.54

0.5

$1.77

3.795

$1.770

$43.90

$45.67

$45.67

$47.44
$39.95

F/DD 16 Facilities)
rcentiles by HSA
Not updated with current figures

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655