

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0048918

Facility Name: Heritage Health-Jacksonville

Address: 873 Grove Street Jacksonville 62650
 Number City Zip Code

County: Morgan

Telephone Number: (217)479-3400 Fax # ()

HFS ID Number: _____

Date of Initial License for Current Owners: July 2007

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: Dave Underwood Telephone Number: 309 823-7135
 Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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) <u>David M. Underwood</u>	
	(Title) <u>Executive VP & CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>()</u> Fax # <u>()</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Heritage Health-Jacksonville

0048918 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	185	Skilled (SNF)	185	67,525	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24		5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	67,525	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,043	23,950	5,335	55,328	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	1,006	3,162		4,168	12
13	DD 16 OR LESS					13
14	TOTALS	27,049	27,112	5,335	59,496	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.11%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started July 2007

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 5,335

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Heritage Health-Jacksonville

0048918

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	527,819	20,884		548,703		548,703	10,532	559,235		1
2	Food Purchase		455,622		455,622		455,622	125	455,747		2
3	Housekeeping	223,487	42,963		266,450		266,450		266,450		3
4	Laundry	108,579	20,386		128,965		128,965		128,965		4
5	Heat and Other Utilities			255,413	255,413		255,413	2,872	258,285		5
6	Maintenance	141,710	151,970	106,421	400,101		400,101	35,883	435,984		6
7	Other (specify):*										7
8	TOTAL General Services	1,001,595	691,825	361,834	2,055,254		2,055,254	49,412	2,104,666		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,509,748	235,986	14,180	3,759,914		3,759,914	610	3,760,524		10
10a	Therapy		899,204	1,209,906	2,109,110	(934,724)	1,174,386		1,174,386		10a
11	Activities	129,744	5,300		135,044		135,044		135,044		11
12	Social Services	80,597	860	5,562	87,019		87,019		87,019		12
13	CNA Training							1,771	1,771		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,720,089	1,141,350	1,241,648	6,103,087	(934,724)	5,168,363	2,381	5,170,744		16
	C. General Administration										
17	Administrative	100,097			100,097		100,097		100,097		17
18	Directors Fees										18
19	Professional Services			523,547	523,547		523,547	(479,889)	43,658		19
20	Dues, Fees, Subscriptions & Promotions			155,915	155,915	(101,288)	54,627	(7,525)	47,102		20
21	Clerical & General Office Expenses	292,621	29,957	29,903	352,481		352,481	645,965	998,446		21
22	Employee Benefits & Payroll Taxes			1,091,182	1,091,182		1,091,182	106,319	1,197,501		22
23	Inservice Training & Education			10,374	10,374		10,374	3,156	13,530		23
24	Travel and Seminar			5,996	5,996		5,996	(997)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			106,991	106,991		106,991	23,799	130,790		26
27	Other (specify):* Lost Resident Items			1,090	1,090		1,090		1,090		27
28	TOTAL General Administration	392,718	29,957	1,924,998	2,347,673	(101,288)	2,246,385	290,828	2,537,213		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,114,402	1,863,132	3,528,480	10,506,014	(1,036,012)	9,470,002	342,621	9,812,623		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							344,393	344,393			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,582	38,582		38,582	121,138	159,720			32
33	Real Estate Taxes							93,709	93,709			33
34	Rent-Facility & Grounds			1,038,060	1,038,060		1,038,060	(1,024,781)	13,279			34
35	Rent-Equipment & Vehicles			23,676	23,676		23,676	16,800	40,476			35
36	Other (specify):*											36
37	TOTAL Ownership			1,100,318	1,100,318		1,100,318	(448,741)	651,577			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					934,724	934,724	2,932	937,656			39
40	Barber and Beauty Shops		759	39,798	40,557		40,557		40,557			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					101,288	101,288		101,288			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		759	39,798	40,557	1,036,012	1,076,569	2,932	1,079,501			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,114,402	1,863,891	4,668,596	11,646,889		11,646,889	(103,188)	11,543,701			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(24,534)			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	(4,853)			17
18	Fines and Penalties				18
19	Entertainment	(17,734)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,648)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,703)			25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,472)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,716)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (24,716)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (103,188)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Health-Jacksonville

ID# 0048918

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		(4,853)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(11,648)	19	22
23				23
24		0	27	24
25		(19,703)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(36,204)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Jacksonville# 0048918

Report Period Beginning:

01/01/14

Ending:

12/31/14

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	10,532	0	0	0	0	0	0	0	0	10,532	1
2	Food Purchase	0	0	125	0	0	0	0	0	0	0	0	125	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,872	0	0	0	0	0	0	0	0	2,872	5
6	Maintenance	0	0	35,883	0	0	0	0	0	0	0	0	35,883	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	49,412	0	0	0	0	0	0	0	0	49,412	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	610	0	0	0	0	0	0	0	0	610	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,771	0	0	0	0	0	0	0	0	1,771	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	2,381	0	0	0	0	0	0	0	0	2,381	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,648)	(510,627)	42,386	0	0	0	0	0	0	0	0	(479,889)	19
20	Fees, Subscriptions & Promotions	(24,556)	0	17,031	0	0	0	0	0	0	0	0	(7,525)	20
21	Clerical & General Office Expenses	0	0	645,965	0	0	0	0	0	0	0	0	645,965	21
22	Employee Benefits & Payroll Taxes	0	0	106,319	0	0	0	0	0	0	0	0	106,319	22
23	Inservice Training & Education	0	0	3,156	0	0	0	0	0	0	0	0	3,156	23
24	Travel and Seminar	(17,734)	0	16,737	0	0	0	0	0	0	0	0	(997)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	23,799	0	0	0	0	0	0	0	0	23,799	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(53,938)	(510,627)	855,393	0	0	0	0	0	0	0	0	290,828	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,938)	(510,627)	907,186	0	0	0	0	0	0	0	0	342,621	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Jacksonville

0048918

Report Period Beginning:

01/01/14

Ending:

12/31/14

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	302,174	0	42,219	0	0	0	0	0	0	0	344,393	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,534)	145,725	0	(53)	0	0	0	0	0	0	0	121,138	32
33	Real Estate Taxes	0	93,709	0	0	0	0	0	0	0	0	0	93,709	33
34	Rent-Facility & Grounds	0	(1,038,060)	0	13,279	0	0	0	0	0	0	0	(1,024,781)	34
35	Rent-Equipment & Vehicles	0	0	0	16,800	0	0	0	0	0	0	0	16,800	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,534)	(496,452)	0	72,245	0	0	0	0	0	0	0	(448,741)	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	2,932	0	0	0	0	0	0	0	0	0	2,932	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	2,932	0	0	0	0	0	0	0	0	0	2,932	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,472)	(1,004,147)	907,186	72,245	0	0	0	0	0	0	0	(103,188)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attachment-See Following Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt Svcs</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>2,932</u>	<u>2,932</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>510,627</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(510,627)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>1,038,060</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(1,038,060)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>93,709</u>	<u>93,709</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>140,952</u>	<u>140,952</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>302,174</u>	<u>302,174</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,548,687			\$ 544,540	\$ * (1,004,147)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$	10,532	15	
16	V	2 Food Purchase						125	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						2,872	19	
20	V	6 Maintenance						35,883	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						610	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,771	26	
27	V	14 Program Transportation						0	27	
28	V	15 Other						0	28	
29	V	17 Administrative						0	29	
30	V	18 Directors Fees						0	30	
31	V	19 Professional Services						42,386	31	
32	V	20 Fees, Subscription, Promotions						17,031	32	
33	V	21 Clerical & General Office Expenses						645,965	33	
34	V	22 Employee Benefits & Payroll Taxes						106,319	34	
35	V	23 Inservice Training & Education						3,156	35	
36	V	24 Travel and Seminar						16,737	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						23,799	38	
39	Total		\$			\$	0	\$ *	907,186	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$	\$	0	15	
16	V	30 Depreciation						42,219	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(53)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						13,279	20	
21	V	35 Rent-Equipment & Vehicles						16,800	21	
22	V	36 Other						0	22	
23	V	38 Medically Nec Transportation						0	23	
24	V	39 Ancillary Service Centers						0	24	
25	V	40 Barber and Beauty Shops						0	25	
26	V	41 Coffee and Gift Shops						0	26	
27	V	42 Other						0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	72,245	39

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

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Heritage Enterprises Inc.	Sole Member	100.00					\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Health-Jacksonville

0048918

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,666	25	\$ 134,342	\$ 134,342	209	\$ 10,532	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	209	125	2
3	3	Housekeeping	Beds	2,666	25	0	0	209	0	3
4	4	Laundry	Beds	2,666	25	0	0	209	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	209	2,872	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	209	35,883	6
7	7	Other	Beds	2,666	25	0	0	209	0	7
8	9	Medical Director	Beds	2,666	25	0	0	209	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	209	610	9
10	11	Activities	Beds	2,666	25	0	0	209	0	10
11	12	Social Service	Beds	2,666	25	0	0	209	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	209	1,771	12
13	14	Program Transportation	Beds	2,666	25	0	0	209	0	13
14	15	Other	Beds	2,666	25	0	0	209	0	14
15	17	Administrative	Beds	2,666	25	0	0	209	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	209	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	209	42,386	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	209	17,031	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	209	645,965	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	209	106,319	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	209	3,156	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	209	16,737	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	209	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	209	23,799	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 907,186	25

Facility Name & ID Number Heritage Health-Jacksonville

0048918

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization See PG 8
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,666	25	\$	\$	209	\$	1
2	30	Depreciation	Beds	2,666	25	538,548	209	42,219	2	
3	31	Amortization of Pre-Op & Org	Beds	2,666	25		209		3	
4	32	Interest	Beds	2,666	25	(682)	209	(53)	4	
5	33	Real Estate Taxes	Beds	2,666	25		209		5	
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393	209	13,279	6	
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306	209	16,800	7	
8	36	Other	Beds	2,666	25		209		8	
9	38	Medically Nec Transportation	Beds	2,666	25		209		9	
10	39	Ancillary Service Centers	Beds	2,666	25		209		10	
11	40	Barber and Beauty Shops	Beds	2,666	25		209		11	
12	41	Coffee and Gift Shops	Beds	2,666	25		209		12	
13	42	Other	Beds	2,666	25		209		13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 921,565	\$	72,245	\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Bank of America		x	Mortgage			\$	\$ 47,000			\$ 140,952	1				
2	Bank of America		x	Loan Fee Amortization							4,773	2				
3												3				
4												4				
5												5				
Working Capital																
6	Bank of America		x	Working Capital							38,582	6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$ 47,000			\$ 184,307	9				
B. Non-Facility Related*																
10	Interest Income										(24,534)	10				
11												11				
12	Allocated Corporate										(53)	12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (24,587)	14				
15	TOTALS (line 9+line14)						\$	\$ 47,000			\$ 159,720	15				

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	93,709		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	93,709		3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	93,709		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	_____	8	FOR BHF USE ONLY		
	2010	_____	9			
	2011	90,521	10			
	2012	90,561	11			
	2013	93,709	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Jacksonville COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0048918

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>0920308003</u>	_____	\$ <u>123,300.96</u>	\$ <u>93,709.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>123,300.96</u></u>	\$ <u><u>93,709.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Heritage Health-Jacksonville

0048918 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	209			\$ 3,295,725	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Facility Sign		2005	1,050					
10	Dietary cabinets		2005	5,864					
11	Ansul system		2005	1,600					
12	Heat detectors		2005	1,777					
13	Door system		2005	17,554					
14	A/C units		2005	10,456					
15									
16	Computer wiring		2005	1,280					
17	A/C compressor		2005	2,849					
18	Shelter care remodel-- paint, flooring, wallpaper		2006	225,040					
19	landscapping		2006	2,262					
20	Boiler		2006	2,580					
21	Heat/cool units		2006	9,517					
22	Fire alarm		2006	2,097					
23	Roof		2006	145,352					
24	Door system		2006	414					
25	Mixing Valve		2006	5,060					
26	Hutton Hall remodel (Shelter Care) -- Window treatments, painting		2006	31,147					
27	sump pump		2006	2,001					
28	2006 audit adjustment		2006	(78,685)					
29									
30									
31									
32									
33	C/O Allocation				42,219		42,219		
34	Book Depreciation				251,259		251,259		
35									
36									

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Backflow preventer	2007	\$ 3,501	\$		\$	\$	\$	37
38	Shower/faucet	2007	875						38
39	Air Handler	2007	5,215						39
40	HVAC	2007	20,152						40
41	Tree removal	2007	9,491						41
42	Valance	2007	581						42
43	Younkin corridor remodel -- paint	2007	16,420						43
44	Trane compressor	2007	2,841						44
45	Elevator	2007	68,750						45
46	Parking lot	2007	10,570						46
47	Aufit Adjustment	2007	(38,621)						47
48									48
49									49
50									50
51									51
52	Nurse Call System	2008	286,152						52
53	Mechanical systems	2008	12,996						53
54	Condensing Unit	2008	17,965						54
55	Laundry plumbing	2008	12,671						55
56	Heat / Cool units	2008	24,201						56
57	Fire Panel	2008	7,378						57
58	Water Heater	2008	5,272						58
59	Kitchen Air Handler	2008	26,187						59
60	Condensing Unit	2008	4,069						60
61	Wireless Phone system	2008	41,983						61
62	Cables-nurse call	2008	21,185						62
63	Resident Phones	2008	10,081						63
64	Audit Adjustment	2008	2,254						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,257,109	\$ 293,478		\$ 293,478	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,257,109	\$ 293,478		\$ 293,478	\$	\$	1
2	Compressor	2009	2,516						2
3	Condensing Unit	2009	16,946						3
4	Boiler Replacement	2009	10,434						4
5	Roof	2009	8,393						5
6	HVAC units	2009	5,735						6
7	Firewall	2009	6,951						7
8	HVAC units	2009	5,106						8
9	Laundry plumbing	2009	7,351						9
10	Sewer ejector	2009	5,189						10
11	Dinning room paint, flooring & labor	2009	55,148						11
12	Cabling	2009	10,874						12
13	Laundry plumbing	2009	7,015						13
14									14
15	Roof Repair	2010	10,654						15
16	heat/cool units	2010	11,449						16
17	Driveway sealant	2010	3,800						17
18	Wanderguard	2010	3,099						18
19	Furnace	2010	4,095						19
20	Carpet	2010	3,523						20
21	Dinning room paint, flooring & labor	2010	53,752						21
22	Boiler Replacement	2010	25,619						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,514,758	\$ 293,478		\$ 293,478	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,514,758	\$ 293,478		\$ 293,478	\$	\$	1
2									2
3	Islandaire stystem	2011	8,122						3
4	PTAC units	2011	21,011						4
5	44 windows	2011	73,900						5
6	roof	2011	8,393						6
7	boiler	2011	19,466						7
8	sign	2011	12,169						8
9	Technology system	2011	22,503						9
10	walk-in cooler	2011	9,893						10
11	furnace	2011	7,952						11
12	Sprinkler system	2011	27,872						12
13									13
14	Technology system	2012	6,347						14
15	Physical Therapy room rehab : Paint, floors labor	2012	164,844						15
16	Boiler	2012	4,397						16
17	Compressor	2012	3,299						17
18	Nurse Call System	2012	15,854						18
19	Condensing Unit	2012	8,079						19
20	Flooring	2012	3,818						20
21									21
22	Lighting Retrofit	2013	7,286						22
23	Elevator Floor Replacement	2013	7,682						23
24	Elevator Door Restrictors	2013	16,400						24
25	PTAC units	2013	12,195						25
26	Roof Replacement	2013	53,982						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,030,222	\$ 293,478		\$ 293,478	\$	\$	34

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

Facility Name & ID Number Heritage Health-Jacksonville

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,030,222	\$ 293,478		\$ 293,478	\$	\$	1
2	Furnace Replacement-Dining Room System	2014	7,036						2
3	Cabling and Electrical - Point of Care Kiosks	2014	10,201						3
4	Install (18) PTAC Units	2014	25,140						4
5	Install New Compressor	2014	7,270						5
6	Replaced Furnace, Condensor, and Humidifier	2014	5,048						6
7	Replaced Water Heater	2014	10,494						7
8	Replace Kitchen Door	2014	3,942						8
9	Install Improvements to (4) Passenger Elevators	2014	26,423						9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,125,776	\$ 293,478		\$ 293,478	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,258,496	\$ 50,915	\$ 50,915	\$		\$	71
72	Current Year Purchases	142,780						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,401,276	\$ 50,915	\$ 50,915	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,627,052	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 344,393	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 344,393	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 23,676 Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 412,894	\$		\$ 412,894	1
2	Licensed Speech and Language Development Therapist		hrs			161,617			161,617	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			599,875	0		599,875	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				899,204		899,204	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					35,520			35,520	13
14	TOTAL			\$		\$ 1,209,906	\$ 899,204		\$ 2,109,110	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Health-Jacksonville

0048918

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 6,865	\$	1
2	Cash-Patient Deposits	12,013		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,770,098		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,180		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,588,107)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (778,951)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (778,951)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 519,754	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,013		28
29	Short-Term Notes Payable	9,171		29
30	Accrued Salaries Payable	585,369		30
31	Accrued Taxes Payable (excluding real estate taxes)	(48,816)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Assessment Tax</u>	128,083		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,205,574	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	47,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 47,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,252,574	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,031,525)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (778,951)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,286,150)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,286,150)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	254,625	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 254,625	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,031,525)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,526,496	1
2	Discounts and Allowances for all Levels	(4,144,670)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,381,826	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,059,584	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,059,584	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,882	12
13	Barber and Beauty Care	49,494	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,744,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	50,618	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,846,917	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	24,534	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,534	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		47,933	28
28a	<u>SC & Apts</u>	540,720	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 588,653	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,901,514	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,055,254	31
32	Health Care	6,103,087	32
33	General Administration	2,347,673	33
B. Capital Expense			
34	Ownership	1,100,318	34
C. Ancillary Expense			
35	Special Cost Centers	40,557	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,646,889	40
41	Income before Income Taxes (line 30 minus line 40)**	254,625	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 254,625	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Health-Jacksonville

0048918

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,897	2,062	\$ 69,387	\$ 33.65	1
2	Assistant Director of Nursing	1,436	1,561	36,598	23.45	2
3	Registered Nurses	17,939	19,287	508,740	26.38	3
4	Licensed Practical Nurses	40,231	43,259	938,333	21.69	4
5	CNAs & Orderlies	142,108	152,804	1,894,933	12.40	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,586	3,856	61,757	16.02	8
9	Activity Director					9
10	Activity Assistants	10,034	10,789	129,744	12.03	10
11	Social Service Workers	3,698	3,976	80,597	20.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,164	45,338	527,819	11.64	15
16	Dishwashers					16
17	Maintenance Workers	9,079	9,762	141,710	14.52	17
18	Housekeepers	21,548	23,170	223,487	9.65	18
19	Laundry	9,955	10,704	108,579	10.14	19
20	Administrator	1,900	2,080	100,097	48.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,112	14,099	292,621	20.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	318,687	342,747	\$ 5,114,402 *	\$ 14.92	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,560		37
38	Nurse Consultant			38
39	Pharmacist Consultant	12,540		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	5,562		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 31,662		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Health-Jacksonville

Report Period Beginning: 01/01/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Michael Schneider			\$ 100,097	Workers' Compensation Insurance	\$ 84,138	IDPH License Fee	\$	
				Unemployment Compensation Insurance	89,563	Advertising: Employee Recruitment	14,144	
				FICA Taxes	391,252	Health Care Worker Background Check (Indicate # of checks performed _____)	2,627	
				Employee Health Insurance	493,374	Patient Background Checks		
				Employee Meals			6,643	
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Benefits	32,855	Dues & Subscriptions	14,438	
				Central Office Allocation	106,319	License & Fees	3,715	
						Central Office Allocation	17,031	
						Less: Public Relations Expense	(6,643)	
						Non-allowable advertising	(4,853)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,097	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,197,501	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 47,102	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								4,734
								0
							Seminar Expense	1,262
								(997)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
C. Professional Services								
Vendor/Payee	Type	Amount						
Heritage Operations Group		\$	511,899					
Legal adj to Zero			11,648					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 523,547					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Jacksonville# 0048918

Report Period Beginning:

01/01/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 101,288
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. \$ 9,865
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg 4 Line #	Adjustment Amount			
1009	PETTY CASH	6,865				1,009		1,009	PETTY CASH	6,865
1010	CASH IN BANK					1,100		1,100	ACCTS RE	1,770,098
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBLE	
1100	ACCOUNTS RECEIVABLE	1,770,098				1,110		1,110	ACCTS RECEIV-M/C	
1110	MEDICARE RECEIVABLES					1,125		1,125	ACCTS RECEIV-IPA	
1125	IPA INCOME RECEIVABLE					1,135		1,135	ACCTS RECEIV-IC	
1130	MEDICARE COST REPORT					1,140		1,140	UNAPPLIED CASH RECEIPTS	
1135	ACCOUNTS RECEIVABLE-IC					1,145		1,145	A/R SUSPENSE-REFUNDS	
1140	UNAPPLIED CASH RECEIPTS					1,200		1,200	PREPAID	20,180
1145	A/R SUSPENSE-REFUNDS					1,220		1,220	OTHER PREPAID EXPENSES	
1190	ACCRUED INTEREST REC					1,300		1,300	DIETARY INVENTORY	
1200	PREPAID INSURANCE	20,180				1,310		1,310	SUPPLIES INVENTORY	
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY	
1300	FOOD INVENTORY					1,409		1,409	LAND	0
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU	0
1409	LAND	0				1,460				0
1450	FURNITURE & EQUIPMENT	0				1,475		1,475	CODE AL	0
1460	ACCUM DEPR-FURN & EQUIP	0				1,490		1,490	ACCUM I	0
1475	BUILDING & IMPROVEMENTS	0				1,530		1,530	RESIDEN	12,013
1490	ACCUM DEPR-BUILDING	0				1,550		1,550	LOAN FE	0
1530	RESIDENT FUNDS	12,013				1,551		1,551	LOAN FEES ADDED	
1550	LOAN FEES	0				1,850		1,850	INTERCO	(2,588,107)
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN	(519,754)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-2,588,107				2,100		2,100	ACCRUEI	(272,905)
2010	ACCOUNTS PAYABLE	-519,754				2,100		2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-272,905				2,110		2,110	ACCRUEI	(312,464)
2110	ACCRUED VACATION PAY	-312,464				2,120		2,120	U.C. TAX	0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	48,816	
2125	FICA TAX PAYABLE	48,816	48,816	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REFUND		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETERIA		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENTS		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUED INTEREST PAYABLE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYMENTS PAYABLE	(128,083)	
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL ESTATE TAX PAYABLE	(9,171)	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-128,083		2,400	2,400 CURRENT PORTION OF LT DEBT		
2350	REAL ESTATE TAX PAYABLE	-9,171		2,512	2,512 DUE TO RESIDENTS	(12,013)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	(47,000)	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEBT		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED EARNINGS	2,286,150	
2460	INCOME TAXES PAYABLE					net income	(254,625)
2512	DUE TO RESIDENTS	-12,013					
2600	MORTGAGE PAYABLE	-47,000				balance	<u>0</u>
2650	EQUIPMENT LOAN PAYABLE						
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	2,286,150					
2970	PROFIT/LOSS FOR PERIOD	-254,625					
3007.1	PATIENT DAYS-PRIVATE	23,950					3,007

3007.2	PATIENT DAYS-IPA	26,043						3,007
3007.3	PATIENT DAYS-MEDICARE	5,335						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE & VA	-9,414,677	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARE	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVATE	-97,999	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-1,744,923	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-4,059,584	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	4,144,670	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	0		6	0	6	0	3,530
3530	13 BEAUTY SHOP	-49,494		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	-286		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-1,596		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-13,820		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-50,190		0	0	0	0	4,110
3600	21 MISC INCOME	-428		0	0	0	0	4,111
4110	GENERAL & ADMINIST WAGES	272,511	292,621	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	100,097	100,097	17	1	0	0	4,120
4115	VACATION & SICK - G&A	20,110		21	1	0	0	4,121
4120	4475 EMPLOYEE BENEFITS	21,537	1,091,182	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	8,689		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP COST	2,629		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250	4255 OFFICE SUPPLIES	29,957	29,957	21	2	0	0	4,275
4260	TELEPHONE	29,903	29,903	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVL	10,374	10,374	23	3	16	0 **	4,280
4280	GENERAL TRAVEL	4,734	5,996	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	1,262		24	3	19	-17,734 ***	4,289
4290	HELP WANTED ADVERTISING	14,144	155,915	20	3	0	0 -101,288	4,290
4291	PROMOTIONAL ADVERTISING	13,060		20	3	25	-13,060	4,291
4292	PUBLIC RELATIONS	6,643		20	3	25	-6,643	4,292
4300	LICENSES & FEES	105,003		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	14,438		20	3	17	-4,853	4,310
4320	CONTRIBUTIONS	0		27	3	20	0	4,320
4350	PROFESSIONAL FEES	12,920	523,547	19	3	22	-11,648	4,350
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSULT	1,560		10	3	0	0	4,364
4363	PHARMACIST FEES	12,540		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	5,562	5,562	12	3	0	0	4,383
4370	TV RENTAL	16,065		35	3	5	0	4,390
4380	INCOME TAXES		1,090	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,627		20	3	26	0	4,401
4400	PAYROLL TAXES	470,425		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	10,390		22	3	0	0	4,420
4410	GROUP INSURANCE	493,374		22	3	0	0	4,430
4420	LIABILITY INSURANCE	106,991	106,991	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	84,138		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	510,627		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	1,090		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	7,611	23,676	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	128,437	141,710	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	13,273		6	1	0	0	4,510
5130	ELECTRIC	135,362	255,413	5	3	0	0	4,600
5131	NATURAL GAS	59,081		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	60,970		5	3	0	0	5,130
5134	TRASH COLLECTION	33,829	106,421	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	24,940	151,970	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	127,030		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	72,592		6	3	0	0	5,140
5210	DIETARY WAGES	476,573	527,819	1	1	0	0	5,160
5220	DIETARY SICK & VAC	51,246		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	465,487	455,622	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	7,896	20,884	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,103		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,885		1	2	0	0	5,260
5295	MEAL CREDIT	-9,865		2	2	0	0	5,270
5310	LAUNDRY WAGES	100,442	108,579	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	8,137		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	9,395	20,386	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	10,991		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	209,058	223,487	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	14,429		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	35,634	42,963	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	7,329		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		3,509,748	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	465,329		10	1	0	0	6,020
6030	DON WAGES	69,387		10	1	0	0	6,030
6035	ADON	36,598		10	1	0	0	6,035
6040	RN SICK & VACATION	43,411		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	861,198		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	77,135		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	1,761,308		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	133,625		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	60,100		10	1	0	0	6,390
6275	REHAB SICK & VAC	1,657		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	179,072	235,986	10	2	0	0	7,281
6295	NURSING SUPPLIES	56,369		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	545		10	2	0	0	7,391
6490	NURSING OTHER	80	14,180	10	3	0	0	7,393
7280	DRUG PURCHASES	314,209	899,204	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	584,995		39	2			7,540
7380	LABORATORY SERVICES	35,520	1,209,906	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	118,552	129,744	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	11,192		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	5,300	5,300	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	599,875		39	3	0	0 ***	7,890
7660	PT SUPPLIES	0		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	72,608	80,597	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	7,989		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	860	860	12	2	0	0	8,130
7740	OT FEE	412,894		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	161,617		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	39,798	39,798	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	759	759	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	1,038,060	1,038,060	34	3	0	0	

8120	INTEREST EXPENSE	38,582	38,582	32	3	14	-24,534	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-24,534		32	0	10	0	
9520	MISC NON-OPERATING INCOME	-540,720		0	0	0	0	
9700	INCOME TAXES	-47,933		0	0	0	0	

11,033,702 11,646,889
613,187

GRAND TOTALS

-254,625 -78,472
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	23,950	23,950
IPA	26,043	26,043
medic	5,335	5,335
		55,328

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3,007 PATIENT	26,043
3,007 PATIENT	5,335
	0

3,010 BASIC CI	(9,414,677)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(97,999)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(1,744,923)
	0

3,110 PHYSICIAN	(4,059,584)
	0

3,112 PHYSICIAN	0
3,113 PHYSICIAN	0

3,140 LABORATORY INCOME	0
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3,152 ST/OT TR	0
3,153 ST/OT TR	0

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
3,411 MEDICAL	0

3,420 MEDICAL	3,967,818
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3,520 RENT INC	0
3,530 BEAUTY	(49,494)
	(286)
3,570 VENDING	(1,596)
3,590 EQUIPMI	(13,820)
3,595 RESIDEN	(50,190)
3,600 MISC INC	(428)
4,110 G&A WA	272,511
4,111 ADMINIS	100,097
4,115 G&A PTC	20,110
4,120 EMPLOY	24,435
4,130 EMPLOY	8,689
4,135 EMPLOY	2,629
4,250 OFFICE S	17,503
4,255 POSTAGI	2,297
4,260 TELEPHC	29,903
4,275 TRAININ	10,374
	0
4,280 GENERA	4,734
4,281 MEAL EX	0
4,285 EDUCAT	1,262
4,289 MEETING	0
4,290 HELP WA	14,144
4,291 PROMOT	13,060
4,292 PUBLIC I	6,643
4,300 LICENSE	105,003
4,310 DUES & :	14,438
4,320 CONTRIE	0
4,350 PROFESS	12,920
4,355 MEDICAL	12,000
	1,560
	12,540

4,364 SOCIAL S	5,562
4,370 TV RENT	16,065
4,383 BACKGR	2,627
4,390 OTHER T	(21,000)
4,400 PAYROL	470,425
4,401 PAYROL	10,390
4,410 GROUP I	493,374
4,420 LIABILIT	106,991
4,430 WORKM	80,577
4,435 W/C-FIRS	771
4,436 DRUG TE	2,790
4,450 MANAGI	510,627
4,460 BAD DEF	0
4,461 BAD DEF	176,852
4,470 LOST ITE	1,090
4,475 UNIFORM	(2,898)
4,486 SERVICE	43,602
4,490 MISC EX	427
4,496 MISC. M.	10,157
4,510 REAL ES	0
4,600 LEASED	7,611
5,110 MAINTEI	128,437
5,120 MAINTEI	13,273
5,130 ELECTRI	135,362
5,131 NATURA	59,081
5,133 WATER &	60,970
5,134 TRASH C	33,829
5,140 PROP/PL	24,940
5,160 GENERA	127,030
5,165 MAINTEI	28,990
5,210 DIETARY	476,573
5,220 DIETARY	51,246
5,248 FOOD PU	465,060

5,250 SUPPLIE	7,896
5,260 REPLACI	3,103
5,270 KITCHEN	9,885
5,295 MEAL IN	(9,865)
5,310 LAUNDR	100,442
5,340 LAUNDR	8,137
5,370 REPLACI	9,395
	0
5,390 SUPPLIE	10,991
5,410 HOUSEK	209,058
5,440 HOUSEK	14,429
5,480 SUPPLIE	35,634
5,490 SUPPLIE	7,329
6,020 RN WAG	465,329
6,030 DON WA	69,387
6,035 ADON W	36,598
6,040 RN PTO &	43,411
6,120 LPN WAG	861,198
6,140 LPN PTO	77,135
6,220 AIDES W	1,761,308
6,240 AIDES PT	133,625
6,245	0
	0
	0
	0
6,270 REHAB V	60,100
6,275 REHAB F	1,657
6,290 NURSINC	179,072
6,295 NURSINC	56,369
6,390 REPLACI	545
6,490 OTHER	80

7,280 DRUG PU	314,209
7,281 DRUG PU	584,995
7,380 LABORA	8,029
7,390 X-RAY S	27,491
	0
7,510 ACTIVIT	118,552
7,540 ACTIVIT	11,192
7,590 ACTIVIT	5,300
7,620 PHYSICA	599,875
7,660 P.T. SUPE	0
7,710 SOCIAL S	72,608
7,720 SOCIAL S	7,989
7,730 SOCIAL S	860
7,740 OCCUPA	412,894
7,770 SPEECH '	161,617
7,820 BEAUTIC	39,798
	759
	0
8,120 INTERES	0
	38,582
8,130 DEPRECI	0
	0
9,510 INTERES	(24,534)
9,520 MISC NO	(26,933)
4,220	0
8,100	1,038,060
9,702	(540,720)
5,230	0
	<u>(254,625)</u>

Expenses Fixed Assets

