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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0050930

Facility Name: Illini Heritage Nursing Center

Address: 1315 Curt Drive, P.O. Box 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
			"Sub-S" Corp.		
		X	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 1/1/2018 to 12/31/2018 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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	12,802	2,994	1,147	16,943	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,802	2,994	1,147	16,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.37%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 795

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	131,102	12,398		143,500		143,500	4,115	147,615			1
2	Food Purchase		112,865		112,865		112,865	(1,035)	111,830			2
3	Housekeeping	120,688	19,309		139,997		139,997	65	140,062			3
4	Laundry	23,130	11,971		35,101		35,101		35,101			4
5	Heat and Other Utilities			73,317	73,317		73,317	210	73,527			5
6	Maintenance	39,328	8,242	13,718	61,288		61,288	2,583	63,871			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	314,248	164,785	87,035	566,068		566,068	5,938	572,006			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,008,282	101,370	16,650	1,126,302		1,126,302	2,670	1,128,972			10
10a	Therapy			253,702	253,702		253,702		253,702			10a
11	Activities	38,372	186	2,008	40,566		40,566	(14,976)	25,590			11
12	Social Services	33,921			33,921		33,921		33,921			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,080,575	101,556	284,360	1,466,491		1,466,491	(12,306)	1,454,185			16
	C. General Administration											
17	Administrative			213,200	213,200		213,200	(148,271)	64,929			17
18	Directors Fees											18
19	Professional Services			8,572	8,572		8,572	12,647	21,219			19
20	Dues, Fees, Subscriptions & Promotions			4,197	4,197		4,197	3,053	7,250			20
21	Clerical & General Office Expenses	31,359	2,714	14,338	48,411		48,411	44,277	92,688			21
22	Employee Benefits & Payroll Taxes			146,304	146,304		146,304	17,734	164,038			22
23	Inservice Training & Education			125	125		125	103	228			23
24	Travel and Seminar							2	2			24
25	Other Admin. Staff Transportation			12,206	12,206		12,206	3,133	15,339			25
26	Insurance-Prop.Liab.Malpractice			2,536	2,536		2,536	25,629	28,165			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	31,359	2,714	401,478	435,551		435,551	(41,693)	393,858			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,426,182	269,055	772,873	2,468,110		2,468,110	(48,061)	2,420,049			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 Nursing Center #0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			16,375	16,375		16,375	50,218	66,593			30
31	Amortization of Pre-Op. & Org.							5,358	5,358			31
32	Interest							82,596	82,596			32
33	Real Estate Taxes							36,942	36,942			33
34	Rent-Facility & Grounds			223,037	223,037		223,037	(223,037)				34
35	Rent-Equipment & Vehicles			15,477	15,477		15,477	905	16,382			35
36	Other (specify):*											36
37	**TOTAL Ownership**			254,889	254,889		254,889	(47,018)	207,871			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,982		40,982		40,982		40,982			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,440	128,440		128,440		128,440			42
43	Other (specify):* Miscellaneous		67	44,698	44,765		44,765	(44,765)				43
44	**TOTAL Special Cost Centers**		41,049	173,138	214,187		214,187	(44,765)	169,422			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,426,182	310,104	1,200,900	2,937,186		2,937,186	(139,844)	2,797,342			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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(1,074)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,454)	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	(7,447)	30		9
10	Interest and Other Investment Income	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(27)	43		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	(28,605)	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				24
25	Fund Raising, Advertising and Promotional	350	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	(25,225)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,528)	Various	$	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)	(71,316)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (71,316)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,844)		37

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

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

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

Illini Heritage Nursing Center

ID# 0050930

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (6,323)	43	1
2	X-Rays-Part A	(3,622)	43	2
3	Miscellaneous Revenue Offset of Office Supplies	(42)	21	3
4	Offset Transportation Revenue	(14,976)	11	4
5	Miscellaneous Revenue Offset of Nursing Supplies	(178)	10	5
6	Disallowed Special Events	(84)	43	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
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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**	(25,225)		49

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,115	$ 4,115	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	39	39	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	65	65	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	210	210	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,614	1,614	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	2,848	2,848	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	213,200	Petersen Health Care Management, Inc.	100.00%	64,929	(148,271)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	12,455	12,455	12
13	V								13
14	Total			$ 213,200			$ 86,275	$ * (126,925)	14

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

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Management, Inc.	100.00%	$ 3,053	$ 3,053	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	42,223	42,223	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,734	17,734	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	103	103	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	2	2	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,133	3,133	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	785	785	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	9,986	9,986	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	90	90	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	2,626	2,626	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	311	311	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	905	905	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			$			$ 80,951	$ * 80,951	39

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

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	6	Maintenance	$	Illini Land LLC	100.00%	$ 969	$ 969	15
16	V	19	Professional Fees		Illini Land LLC	100.00%	192	192	16
17	V	21	Equipment	$	Illini Land LLC	100.00%	2,096	2,096	17
18	V	26	Property Insurance		Illini Land LLC	100.00%	18,480	18,480	18
19	V	26	Mortgage Insurance		Illini Land LLC	100.00%	6,364	6,364	19
20	V	30	Depreciation		Illini Land LLC	100.00%	47,679	47,679	20
21	V	31	Amortization		Illini Land LLC	100.00%	5,268	5,268	21
22	V	32	Interest	185	Illini Land LLC	100.00%	80,201	80,016	22
23	V	33	Real Estate Taxes		Illini Land LLC	100.00%	36,631	36,631	23
24	V	34	Rent-Facility & Grounds	223,037	Illini Land LLC	100.00%	0	(223,037)	24
25	V						0		25
26	V						0		26
27	V						0		27
28	V						0		28
29	V						0		29
30	V						0		30
31	V						0		31
32	V						0		32
33	V						0		33
34	V						0		34
35	V						0		35
36	V						0		36
37	V						0		37
38	V						0		38
39	Total			$ 223,222			$ 197,880	$ * (25,342)	39

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

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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, I	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 Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care `	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care `	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 Management, 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	1,411,762	75	$ 342,871	$ 393,211	16,943	$ 4,115	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	16,943	39	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	16,943	65	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	16,943	210	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	16,943	1,614	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	16,943	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	16,943	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	16,943	2,848	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	16,943	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	16,943	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	16,943	64,929	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	16,943	12,455	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	16,943	3,053	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	16,943	42,223	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	16,943	17,734	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	16,943	103	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	16,943	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	16,943	3,133	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	16,943	785	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	16,943	9,986	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	16,943	90	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	16,943	2,626	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	16,943	311	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	16,943	905	24
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 167,226	25

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 1,257,246	9/1/37	0.0630	$ 80,201	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	$ 1,257,246			$ 80,201	9
	B. Non-Facility Related*											
10								Interest Income Offset			(231)	10
11								Home Office Allocation-PHCM			2,626	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,395	14
15	TOTALS (line 9+line14)						$ 1,615,000	$ 1,257,246			$ 82,596	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,364 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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	30,000	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.)	$	32,631	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,631	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,000	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**		311	
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.	$	36,942	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	28,965	8
	2014	29,228	9
	2015	29,479	10
	2016	29,256	11
	2017	32,631	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illini Heritage Nursing Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0050930

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 32,630.80	$ 32,630.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,630.80	$ 32,630.80

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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: 5,358 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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 783,838	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Paving			1997	16,431		39	421	421	8,999	9
10	Water Heater			1997	4,300		39	110	110	2,406	10
11	Laundry Repair			1997	1,633		39	42	42	908	11
12	Remodeling			1997	30,803		39	790	790	18,368	12
13	Remodeling			1997	11,351		15			11,351	13
14	Paving			1998	2,900		39	74	74	1,526	14
15	Tiling			1999	38,000		27.5	1,382	1,382	27,006	15
16	Birdhouse			1999	4,043		27.5	147	147	2,811	16
17	Parking Lot Paving			1999	5,900		27.5	215	215	4,129	17
18	Roof Repair			2003	4,160		39	107	107	1,654	18
19	Blinds			2007	4,571		10			4,571	19
20	Water Heaters			2007	11,705		15	780	780	8,970	20
21	Roof Replacement			2007	87,945		20	4,398	4,398	47,679	21
22	Windows			2008	16,695		20	834	834	8,757	22
23	Door			2008	2,793		15	186	186	1,953	23
24	Blinds			2008	3,481		10	175	175	3,481	24
25	Parking Lot Repair			2011	5,816		7	421	421	5,816	25
26	Door Replacement			2013	2,911		7	416	416	2,288	26
27	Window Replacements			2016	38,840		25	1,554	1,554	3,885	27
28	Roof Repair			2016	4,560		7	652	652	1,630	28
29	Electric Heater			2017	5,307		7	758	758	1,137	29
30	Sidewalk and Patio Repair			2017	3,500		7	500	500	750	30
31	Gutter Repair			2017	4,200		7	600	600	900	31
32	Air Conditioner			2018	10,535		15	351	351	351	32
33											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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Building Improvement Booked			10,822			(10,822)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,302,180	$ 10,822		$ 50,542	$ 39,720	$ 955,164	70

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

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 64,275	$ 5,127	$ 5,833	$ 706	5-10 yrs.	$ 44,184	71
72	Current Year Purchases	3,251	426	232	(194)	7 yrs.	232	72
73	Fully Depreciated Assets	362,195					362,195	73
74	Home Office Allocation			9,986	9,986			74
75	TOTALS	$ 429,721	$ 5,553	$ 16,051	$ 10,498		$ 406,611	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	$	$	$		$ 16,131	76
77										77
78										78
79										79
80	TOTALS			$ 16,131	$	$	$		$ 16,131	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)	$ 1,789,432	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,375	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,593	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 50,218	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,377,906	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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 16,382 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					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 Nursing Center
0050930
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 11,753
Dishwasher	701
Copier	3,023
Home Office Allocation	905
	16,382

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

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	$		$ 115,505	$		$ 115,505	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			43,606			43,606	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs			94,360			94,360	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				40,982		40,982	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Restorative Aides	10A(1)	1798 hrs	26,971				1,798	26,971	12
13	Other (specify): Respiratory Therapy	10A(3)				231			231	13
14	TOTAL			$ 26,971		$ 253,702	$ 40,982	1,798	$ 321,655	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 Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 182,898	$ 183,098	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,669)	1,059,263	1,059,263	3
4	Supply Inventory (priced at Cost)	9,085	9,085	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,539	46,377	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	339	339	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,280,124	$ 1,298,162	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		979,800	14
15	Leasehold Improvements, at Historical Cost	227,114	322,380	15
16	Equipment, at Historical Cost	83,485	445,852	16
17	Accumulated Depreciation (book methods)	(164,548)	(1,377,906)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		184,186	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(86,023)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): RE Entity Escrow Reserves		527,479	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 146,051	$ 1,037,168	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,426,175	$ 2,335,330	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 389,461	$ 407,052	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,309	82,309	30
31	Accrued Taxes Payable (excluding real estate taxes)	301,120	301,120	31
32	Accrued Real Estate Taxes(Sch.IX-B)		34,000	32
33	Accrued Interest Payable		6,601	33
34	Deferred Compensation	148,382	629,499	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	645	645	36
37	Accrued Management Fees	732,902	732,902	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,654,819	$ 2,194,128	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,257,246	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,662,500	1,771,045	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,662,500	$ 3,028,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,317,319	$ 5,222,419	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,891,144)	$ (2,887,089)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,426,175	$ 2,335,330	48

***(See instructions.)**

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,743,754)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,743,754)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(115,390)	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	(32,000)	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)**	$ (147,390)	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)**	$ (1,891,144)	24 *

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

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,493,936	1
2	Discounts and Allowances for all Levels	(277,624)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,216,312	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	512,720	6
7	Oxygen	3,567	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 516,287	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	1,074	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	65,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,739	20
21	Other Medical Services	1,800	21
22	Laundry	29	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 73,955	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Transportation Revenue**	14,976	28
28a	**Miscellaneous Revenue**	220	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,196	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,821,796	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	566,068	31
32	Health Care	1,466,491	32
33	General Administration	435,551	33
	B. Capital Expense		
34	Ownership	254,889	34
	C. Ancillary Expense		
35	Special Cost Centers	85,747	35
36	Provider Participation Fee	128,440	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,937,186	40
41	**Income before Income Taxes (line 30 minus line 40)****	(115,390)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (115,390)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,656,209	44
45	Private Pay - Net Inpatient Revenue	475,680	45
46	Medicare - Net Inpatient Revenue	62,008	46
47	Other-(specify) **Insurance Net Inpatient Revenue**	22,415	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,216,312	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,985	1,985	$ 71,724	$ 36.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,538	2,586	72,646	28.09	3
4	Licensed Practical Nurses	13,633	14,091	341,170	24.21	4
5	CNAs & Orderlies	32,152	32,712	427,735	13.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,809	1,867	26,971	14.45	8
9	Activity Director	905	933	13,781	14.77	9
10	Activity Assistants					10
11	Social Service Workers	1,963	1,979	33,921	17.14	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,470	18.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,088	10,200	93,632	9.18	15
16	Dishwashers					16
17	Maintenance Workers	2,126	2,126	39,328	18.50	17
18	Housekeepers	11,998	12,258	120,688	9.85	18
19	Laundry	2,682	2,780	23,130	8.32	19
20	Administrator	2,311	2,311	64,929	28.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,836	1,892	31,359	16.57	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 Care(specify)					32
33	Other(specify) Page 20A	4,232	4,232	92,627	21.89	33
34	TOTAL (lines 1 - 33)	92,338	94,032	$ 1,491,111 *	$ 15.86	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	4,703	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)		$ 16,703		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	144	4,730	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	144	$ 4,730		53

Illini Heritage Nursing Center
0050930
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,223	2,223	68,036	30.61
Transportation	2,009	2,009	24,591	12.24
TOTAL	4,232	4,232	92,627	

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jessica Lane	Administrator	0	$ 27,012
Valerie Tinsman	Administrator	0	37,917
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,929

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 213,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 213,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Comcast Cable	Computer Services	$ 1,704
JP Morgan Chase	Legal Fees	183
Ability Network	Computer Services	1,843
First Midwest Bank	Legal Fees	61
Talcott Resolution Life	Legal Fees	49
CIOX Health	Legal Fees	32
State Farm Bank	Legal Fees	35
Ginoli	Accounting Fees	4,665
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,572

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,062
Unemployment Compensation Insurance	18,815
FICA Taxes	108,437
Employee Health Insurance	1,127
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,401
Home Office Allocation	17,734
Employee Retirement	462
TOTAL (agree to Schedule V, line 22, col.8)	$ 164,038

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 17)	510
Patient Background Checks	884
Miscellaneous Licenses & Permits	813
Home Office Allocation	3,053
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,250

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	2
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2

* Attach copy of IMRF notifications

**See instructions.

Illini Heritage Nursing Center
0050930
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,572
Home Office Allocation		
Duane Morris	Legal	1703
Sedgwick CMS	Legal	151
SB2	Legal	420
Miscellaneous	Legal	125
Christoper P. Ryan	Legal	133
Saul Ewing Arnstein & Lehr	Legal	596
Healthcare Resources International	Legal	89
Winston & Strawn	Legal	1435
Lexis Nexis	Legal	6
Pretzel & Stouffer	Legal	21
Berkadia	Legal	192
CliftonLarsonAllen	Accounting	871
Ginoli & Co.	Accounting	309
Duane Morris	Accounting	51
Getzler Henrich & Associates	Accounting	669
Kemper Consulting	Accounting	51
Baker Tilly Virchow Krause	Accounting	352
Miscellaneous	Computer Services	89
Change Healthcare	Computer Services	3
TR Professional	Computer Services	9
Matrix Care	Computer Services	978
Ability Network	Computer Services	1548
Stratus Networks	Computer Services	379
Kemper Technology	Computer Services	435
AT&T	Computer Services	5
Ungerboeck Software	Computer Services	313
CIAN	Computer Services	136
Comcast	Computer Services	34
CCH	Computer Services	13
Charter Communications	Computer Services	23
Allscripts	Computer Services	440
ATS	Computer Services	204
Citrix Systems	Computer Services	72
Optimizer	Other Prof Fees	40
Sedgwick CLMS	Other Prof Fees	138
David Budde	Other Prof Fees	39
Sargent Consulting	Other Prof Fees	108
Alix Partners	Other Prof Fees	411
Getzler Henrich & Associates	Other Prof Fees	56
Total (agree to Schedule V, line 19, column 8)		21,219

Illini Heritage Rehab & Health Care Center
Other Administrative Staff Transportation Schedule
1/1-12/31 2018

Employee Name & Title	Date	Type of Expense	Expense
Transportation Dept.	Jan-18	Gas for Van	300.17
Transportation Dept.	Jan-18	Oil Change	34.43
Transportation Dept.	Feb-18	Gas for Van	559.38
Car-X	Feb-18	Van Repair	374.42
Transportation Dept.	Mar-18	Gas for Van	246.55
Lisa Babb-Community Resource Coorodinator	Mar-18	Mileage Reimbursement-598 miles	179.40
Transportation Dept.	Apr-18	Gas for Van	333.47
CCM Champaign County Mobility	Apr-18	Van Repair	1,189.32
Kenna Williamson-Transportation Dept.	Apr-18	Mileage Reimbursement-179.2 miles	53.76
Transportation Dept.	May-18	Gas for Van	277.81
CCM Champaign County Mobility	May-18	Van Repair	507.22
Roseman Corp.	May-18	Oil Change	25.00
Transportation Dept.	Jun-18	Gas for Van	503.90
Transportation Dept.	Jul-18	Gas for Van	332.75
CCM Champaign County Mobility	Jul-18	Van Repair	366.72
Lisa Babb-Community Resource Coorodinator	Jul-18	Reimbursement for Hotel Stay	(225.00)
Transportation Dept.	Aug-18	Gas for Van	285.68
Greg's Truck and Auto Repair	Aug-18	Oil Change	80.00
Adaine Zalman-Marketing Dept.	Aug-18	Mileage Reimbursement-160 miles	48.00
Transportation Dept.	Sep-18	Gas for Van	282.90
Transportation Dept.	Oct-18	Gas for Van	212.67
CCM Champaign County Mobility	Oct-18	Van Repair	626.65
Transportation Dept.	Nov-18	Gas for Van	216.54
Tires Plus	Nov-18	Oil Change	34.43
Greg's Truck and Auto Repair	Nov-18	Van Repair	1,237.25
Pro Automotive	Nov-18	Van Repair	2,403.50
Transportation Dept.	Nov-18	Oil Change	50.00
Transportation Dept.	Dec-18	Gas for Van	396.09
Greg's Truck and Auto Repair	Dec-18	Van Repair	1,239.03
Tires Plus	Dec-18	Oil Change	34.43
		Total	12,206.47

Facility Name & ID Number Illini Heritage Nursing Center # 0050930 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. **IHCA-**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,674** 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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **128,440**
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. $ **1,074**

(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. $ **14,976**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

RECONCILIATION REPORT **Illini Heritage Nursing C** **12:12 PM** **7/25/2019**

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	-139,844	equal to	-139,844	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	82,596	equal to	82,596	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	36,942	equal to	36,942	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening	5,358	equal to	5,358	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	66,593	equal to	66,593	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	16,382	equal to	16,382	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	253,702	equal to	253,702	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	40,982	equal to	40,982	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	566,068	equal to	566,068	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,466,491	equal to	1,466,491	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	435,551	equal to	435,551	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	254,889	equal to	254,889	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	85,747	equal to	85,747	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	128,440	equal to	128,440	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,008,282	equal to	1,008,282	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	38,372	equal to	38,372	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	33,921	equal to	33,921	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	131,102	equal to	131,102	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	39,328	equal to	39,328	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	120,688	equal to	120,688	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	23,130	equal to	23,130	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	64,929	equal to	64,929	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	31,359	equal to	31,359	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	1,491,111	equal to	1,426,182	64,929	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	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	9,433	< or = to	16,650	-7,217	O.K.	Pg20 X14..X16	B. & C.	/7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	2,008	-2,008	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.	64,929	equal to	64,929	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	213,200	equal to	213,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	8,572	equal to	8,572	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	164,038	equal to	164,038	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,250	equal to	7,250	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2	equal to	2	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	128,440	equal to	128,440	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
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	795	equal to	1,147	-352	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. cos	-71,316	equal to	-71,316	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,257,246	equal to	1,257,246	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	34,000	equal to	34,000	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	1,302,180	equal to	1,302,180	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	445,852	equal to	445,852	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,377,906	equal to	1,377,906	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,891,144	equal to	-1,891,144	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-115,390	equal to	-115,390	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. co	0	equal to		0	O.K.	Pg22 F31-J31..I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,426,175	equal to	1,426,175	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 7/25/2019 12:12:22 PM

HSA Number: 4 Name: **Illini Heritage Nursing Center**

Cost report peri From:	1/1/2018	To:	12/31/2018	Base Number:	516
If this is an ICF/DD 16 facility, e	N				
Licensed bed d	21,900	Occupancy:	16,943	Pct. of occupan	77.37%

ıblic Aid Support Rate: $ ________

Genl Services S	314,248	Col 1, Line 8 ---Audit Adj:	________
Genl Admin Sal	31,359	Col 1, Line 28 ---Audit Adj:	________
Total Salary Wa	1,426,182	Col 1, Line 44 ---Audit Adj:	________
Employee Bene	164,038	Col 8, Line 22 ---Audit Adj:	________
Total General S	572,006	Col 8, Line 8 ---Audit Adj:	________
Total General A	393,858	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)	$314,248
Divided by Total Wages (Column 1, Line 44)	$1,426,182
General service wages as percent of total wages	22.0342%
Employee Benefits (Column 10, Line 22)	$164,038
Allocation of Employee Benefits to General Services Costs	$36,144
Plus Total General Services (Column 10, Line 8)	$572,006
New Total General Services Cost	$608,150

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).	$31,359
Divided by Total Wages (Column 1, Line 45)	$1,426,182
General administration wages as a percent of total wages	2.1988%
Employee Benefits (Column 10, Line 22)	$164,038
Allocation of Employee Benefits to General Admin. Costs	$3,607
Plus Total General Administration (Column 10, Line 28)	$393,858
Minus Total Fringe (Column 10, Line 22)	$164,038
New Total General Administration Cost	$233,427

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 Mon	13	divided by 2 =	6.5
Beginning Day + Ending Day =	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	236	multiplied by 6 =	1416
Sum of the three lines			1423.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			516

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:	1
General Administration Multiplier:	1

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)	$608,150	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$608,150

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)	$233,427	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$233,427
3 Total Updated Support Costs (1 + 2)		$841,577

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 $46.54

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)	$841,577
Total Patient Days (Cost Report)	16,943
Support Costs per Diem	$49.67

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	21,900
Multiplied by	0.93
	20,367
Minus total Patient Days	16,943
	3,424
One-third of difference	1,141
Plus Total Patient Days	16,943
Adjusted Occupancy	18,084
Total Support Costs (Step II, C, 3, above)	$841,577
Divided by Adjusted Occupany	18084
Support Costs Per Diem	$46.54

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	$47.44
Minus Support Costs Per Diem	$46.54
Difference	$0.90
Multiply the Difference by	0.5
One-Half of the Difference	$0.45
Plus Support Costs Per Diem	$46.54
Support Rate if costs are between 35th and 75th percentile	46.99

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	$47.44
Minus Support Costs Per Diem	$46.54
Difference	$0.90
Multiply the Difference by	0.5
One-Half of the Difference	$0.45
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$0.450
Plus Support Costs Per Diem	$46.54
Support Rate if support costs less than 35th percentile	$46.99

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$46.99**

75th Percentile is	$47.44
35th Percentile is	$39.95

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/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	131,102	12,398	0	143,500	0	143,500	4,115	147,615
2. Food Purchase	0	112,865	0	112,865	0	112,865	-1,035	111,830
3. Housekeeping	120,688	19,309	0	139,997	0	139,997	65	140,062
4. Laundry	23,130	11,971	0	35,101	0	35,101	0	35,101
5. Heat and Other Utilities	0	0	73,317	73,317	0	73,317	210	73,527
6. Maintenance	39,328	8,242	13,718	61,288	0	61,288	2,583	63,871
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	314,248	164,785	87,035	566,068	0	566,068	5,938	572,006
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	########	101,370	16,650	1,126,302	0	1,126,302	2,670	#######
10a. Therapy	0	0	253,702	253,702	0	253,702	0	253,702
11. Activities	38,372	186	2,008	40,566	0	40,566	-14,976	25,590
12. Social Services	33,921	0	0	33,921	0	33,921	0	33,921
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	########	101,556	284,360	1,466,491	0	1,466,491	-12,306	#######
17. Administrative	0	0	213,200	213,200	0	213,200	-148,271	64,929
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,572	8,572	0	8,572	12,647	21,219
20. Fees, Subscriptions & Promotion	0	0	4,197	4,197	0	4,197	3,053	7,250
21. Clerical & General Office	31,359	2,714	14,338	48,411	0	48,411	44,277	92,688
22. Employee Benefits & Payroll	0	0	146,304	146,304	0	146,304	17,734	164,038
23. Inservice Training & Education	0	0	125	125	0	125	103	228
24. Travel and Seminar	0	0	0	0	0	0	2	2
25. Other Admin. Staff Trans	0	0	12,206	12,206	0	12,206	3,133	15,339
26. Insurance-Prop.Liab.Malpractice	0	0	2,536	2,536	0	2,536	25,629	28,165
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	31,359	2,714	401,478	435,551	0	435,551	-41,693	393,858
29. Total General Administrative	########	269,055	772,873	2,468,110	0	2,468,110	-48,061	#######
30. Depreciation	0	0	16,375	16,375	0	16,375	50,218	66,593
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	5,358	5,358
32. Interest	0	0	0	0	0	0	82,596	82,596
33. Real Estate	0	0	0	0	0	0	36,942	36,942
34. Rent - Facility & Grounds	0	0	223,037	223,037	0	223,037	-223,037	0
35. Rent - Equipment & Vehicles	0	0	15,477	15,477	0	15,477	905	16,382
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	254,889	254,889	0	254,889	-47,018	207,871
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	40,982	0	40,982	0	40,982	0	40,982
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	128,440	128,440	0	128,440	0	128,440
43. Other (specify):*	0	67	44,698	44,765	0	44,765	-44,765	0
44. Total Special Cost Ce	0	41,049	173,138	214,187	0	214,187	-44,765	169,422
45. Grand Total	########	310,104	########	2,937,186	0	2,937,186	-139,844	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	182,898	183,098
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,059,263	1,059,263
4. Supply Inventory	9,085	9,085
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,539	46,377
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	339	339
10. Total current assets	1,280,124	1,298,162
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	979,800
15. Leasehold Improvements, Historical Cost	227,114	322,380
16. Equipment, at Historical Cost	83,485	445,852
17. Accumulated Depreciation (book methods)	-164,548	-1,377,906
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	184,186
20. Accum Amort - Org/Pre-Op Costs	0	-86,023
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	527,479
24. Total Long-Term Assets	146,051	1,037,168
25. Total Assets	1,426,175	2,335,330
CURRENT LIABILITIES		
26. Accounts Payable	389,461	407,052
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	82,309	82,309
31. Accrued Taxes Payable	301,120	301,120
32. Accrued Real Estate Taxes	0	34,000
33. Accrued Interest Payable	0	6,601
34. Deferred Compensation	148,382	629,499
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	645	645
37. Other Current Liabilities (specify):	732,902	732,902
38. Total Current Liabilities	1,654,819	2,194,128
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	1,257,246
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,662,500	1,771,045
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,662,500	3,028,291
46.Total Liabilities	3,317,319	5,222,419
47.Total Equity	########	-2,887,089
48.Total Liabilities and Equity	1,426,175	2,335,330

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,493,936
2. Discounts and Allowances for all Levels	-277,624
Subtotal - Inpatient Care	2,216,312
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	512,720
7. Oxygen	3,567
Subtotal - Anciliary Revenue	516,287
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	1,074
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	65,313
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	5,739
21. Other Medical Services	1,800
22. Laundry	29
Subtotal - Other Operating Revenue	73,955
24. Contributions	0
25. Interest and Other Investments Income	46
Subtotal - Non-Operating Revenue	46
27. Other Revenue (specify):	14,976
28. Other Revenue (specify):	220
Subtotal - Other Revenue	15,196
30. Total Revenue	2,821,796
31. General Services	566,277
32. Health Care	1,287,087
33. General Administration	419,896
34. Ownership	272,432
35. Special Cost Centers	77,155
35. Provider Participation Fee	134,844
37. Other	0
40. Total Expenses	2,757,691
41. Income Before Income Taxes	64,105
42. Income Taxes	0
43. Net Income or Loss for the Year	64,105