

Facility Name & ID Number Heritage Health-Litchfield

0048900 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1	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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	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	15,156	7,218	3,836	26,210	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,156	7,218	3,836	26,210	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.40%

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 3,836

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL 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-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				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	171,046	9,303		180,349		180,349	7,188	187,537		1
2	Food Purchase		174,269		174,269		174,269	31	174,300		2
3	Housekeeping	102,632	24,853		127,485		127,485	4	127,489		3
4	Laundry	43,631	16,856		60,487		60,487		60,487		4
5	Heat and Other Utilities			84,625	84,625		84,625	1,578	86,203		5
6	Maintenance	53,567	44,505	47,183	145,255		145,255	15,604	160,859		6
7	Other (specify):*										7
8	TOTAL General Services	370,876	269,786	131,808	772,470		772,470	24,405	796,875		8
	B. Health Care and Programs										
9	Medical Director			28,566	28,566		28,566		28,566		9
10	Nursing and Medical Records	1,356,262	98,119	8,423	1,462,804		1,462,804	2,785	1,465,589		10
10a	Therapy		305,726	611,898	917,624	(335,250)	582,374		582,374		10a
11	Activities	39,016	1,134		40,150		40,150		40,150		11
12	Social Services	57,188		1,563	58,751		58,751		58,751		12
13	CNA Training							602	602		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,452,466	404,979	650,450	2,507,895	(335,250)	2,172,645	3,387	2,176,032		16
	C. General Administration										
17	Administrative	93,956			93,956		93,956		93,956		17
18	Directors Fees										18
19	Professional Services			218,109	218,109		218,109	(198,075)	20,034		19
20	Dues, Fees, Subscriptions & Promotions			84,160	84,160	(55,845)	28,315	(4,017)	24,298		20
21	Clerical & General Office Expenses	92,078	20,268	9,612	121,958		121,958	298,198	420,156		21
22	Employee Benefits & Payroll Taxes			454,686	454,686		454,686	45,246	499,932		22
23	Inservice Training & Education			5,973	5,973		5,973	605	6,578		23
24	Travel and Seminar			5,961	5,961		5,961	(3,962)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			44,885	44,885		44,885	11,300	56,185		26
27	Other (specify):*			19,025	19,025		19,025	(19,000)	25		27
28	TOTAL General Administration	186,034	20,268	842,411	1,048,713	(55,845)	992,868	130,295	1,123,163		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,009,376	695,033	1,624,669	4,329,078	(391,095)	3,937,983	158,087	4,096,070		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							245,619	245,619			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,990	18,990		18,990	89,357	108,347			32
33	Real Estate Taxes							71,673	71,673			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,012)	6,748			34
35	Rent-Equipment & Vehicles			10,374	10,374		10,374	4,801	15,175			35
36	Other (specify):*											36
37	TOTAL Ownership			476,124	476,124		476,124	(28,562)	447,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					335,250	335,250	1,687	336,937			39
40	Barber and Beauty Shops		734	12,673	13,407		13,407		13,407			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,845	55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		734	12,673	13,407	391,095	404,502	1,687	406,189			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,009,376	695,767	2,113,466	4,818,609		4,818,609	131,212	4,949,821			45

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning: 01/01/13

Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

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

		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	(21,039)			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	(642)			17
18	Fines and Penalties				18
19	Entertainment	(11,113)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,640)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,000)			24
25	Fund Raising, Advertising and Promotional	(13,857)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,291)		\$	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)	200,503		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 200,503		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 131,212		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-Litchfield

ID# 0048900

Report Period Beginning: 01/01/13

Ending: 12/31/13

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		(642)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,640)	19	22
23				23
24		(19,000)	27	24
25		(13,857)	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		(37,139)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Litchfield# 0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	7,188	0	0	0	0	0	0	0	0	7,188	1
2	Food Purchase	0	0	31	0	0	0	0	0	0	0	0	31	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,578	0	0	0	0	0	0	0	0	1,578	5
6	Maintenance	0	0	15,604	0	0	0	0	0	0	0	0	15,604	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	24,405	0	24,405	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,785	0	0	0	0	0	0	0	0	2,785	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	602	0	0	0	0	0	0	0	0	602	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	3,387	0	3,387	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	(3,640)	(214,469)	20,034	0	0	0	0	0	0	0	0	(198,075)	19
20	Fees, Subscriptions & Promotions	(14,499)	0	10,482	0	0	0	0	0	0	0	0	(4,017)	20
21	Clerical & General Office Expenses	0	0	298,198	0	0	0	0	0	0	0	0	298,198	21
22	Employee Benefits & Payroll Taxes	0	0	45,246	0	0	0	0	0	0	0	0	45,246	22
23	Inservice Training & Education	0	0	605	0	0	0	0	0	0	0	0	605	23
24	Travel and Seminar	(11,113)	0	7,151	0	0	0	0	0	0	0	0	(3,962)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	11,300	0	0	0	0	0	0	0	0	11,300	26
27	Other (specify):*	(19,000)	0	0	0	0	0	0	0	0	0	0	(19,000)	27
28	TOTAL General Administration	(48,252)	(214,469)	393,016	0	130,295	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,252)	(214,469)	420,808	0	158,087	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	226,481	0	19,138	0	0	0	0	0	0	0	245,619	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,039)	109,961	0	435	0	0	0	0	0	0	0	89,357	32
33	Real Estate Taxes	0	71,673	0	0	0	0	0	0	0	0	0	71,673	33
34	Rent-Facility & Grounds	0	(446,760)	0	6,748	0	0	0	0	0	0	0	(440,012)	34
35	Rent-Equipment & Vehicles	0	0	0	4,801	0	0	0	0	0	0	0	4,801	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(21,039)	(38,645)	0	31,122	0	(28,562)	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	1,687	0	0	0	0	0	0	0	0	0	1,687	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	1,687	0	0	0	0	0	0	0	0	0	1,687	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,291)	(251,427)	420,808	31,122	0	131,212	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>See Pg 25</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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$					1
2	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>1,687</u>	<u>1,687</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>214,469</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(214,469)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>446,760</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(446,760)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>71,673</u>	<u>71,673</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>104,058</u>	<u>104,058</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>226,481</u>	<u>226,481</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,903</u>	<u>5,903</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 661,229			\$ 409,802	\$ * (251,427)	14

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

Facility Name & ID Number

Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES (continued)

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

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

1	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.		\$	\$ 7,188	15
16	V	2 Food Purchase					31	16
17	V	3 Housekeeping					4	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,578	19
20	V	6 Maintenance					15,604	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					2,785	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					602	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					20,034	31
32	V	20 Fees, Subscription, Promotions					10,482	32
33	V	21 Clerical & General Office Expenses					298,198	33
34	V	22 Employee Benefits & Payroll Taxes					45,246	34
35	V	23 Inservice Training & Education					605	35
36	V	24 Travel and Seminar					7,151	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					11,300	38
39	Total		\$			\$	0	\$ * 420,808 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.		\$	\$	15
16	V	30 Depreciation					19,138	16
17	V	31 Amortization of Pre-Op & Org					0	17
18	V	32 Interest					435	18
19	V	33 Real Estate Taxes					0	19
20	V	34 Rent-Facility & Grounds					6,748	20
21	V	35 Rent-Equipment & Vehicles					4,801	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	\$ * 31,122 39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heritage Health-Litchfield # 0048900 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	2,604	24	\$ 183,508	\$ 183,106	102	\$ 7,188	1
2	2	Food Purchase	Beds	2,604	24	798	0	102	31	2
3	3	Housekeeping	Beds	2,604	24	106	0	102	4	3
4	4	Laundry	Beds	2,604	24	0	0	102	0	4
5	5	Heat & Other Utilities	Beds	2,604	24	40,282	0	102	1,578	5
6	6	Maintenance	Beds	2,604	24	398,350	84,311	102	15,604	6
7	7	Other	Beds	2,604	24	0	0	102	0	7
8	9	Medical Director	Beds	2,604	24	0	0	102	0	8
9	10	Nursing & Medical Records	Beds	2,604	24	71,096	69,815	102	2,785	9
10	11	Activities	Beds	2,604	24	0	0	102	0	10
11	12	Social Service	Beds	2,604	24	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,604	24	15,364	15,279	102	602	12
13	14	Program Transportation	Beds	2,604	24	0	0	102	0	13
14	15	Other	Beds	2,604	24	0	0	102	0	14
15	17	Administrative	Beds	2,604	24	0	0	102	0	15
16	18	Directors Fees	Beds	2,604	24	0	0	102	0	16
17	19	Professional Services	Beds	2,604	24	511,456	0	102	20,034	17
18	20	Fees, Subscription, Promotions	Beds	2,604	24	267,591	0	102	10,482	18
19	21	Clerical & General Office Expens	Beds	2,604	24	7,612,820	7,140,260	102	298,198	19
20	22	Employee Benefits & Payroll Tax	Beds	2,604	24	1,155,097	0	102	45,246	20
21	23	Inservice Training & Education	Beds	2,604	24	15,452	0	102	605	21
22	24	Travel and Seminar	Beds	2,604	24	182,552	0	102	7,151	22
23	25	Other Admin. Staff Transportatio	Beds	2,604	24	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,604	24	288,473	0	102	11,300	24
25	TOTALS					\$ 10,742,945	\$ 7,492,771		\$ 420,808	25

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	27	Other	Beds	2,604	24	\$	\$	102	\$	1
2	30	Depreciation	Beds	2,604	24	488,578	102	19,138		2
3	31	Amortization of Pre-Op & Org	Beds	2,604	24		102			3
4	32	Interest	Beds	2,604	24	11,093	102	435		4
5	33	Real Estate Taxes	Beds	2,604	24		102			5
6	34	Rent-Facility & Grounds	Beds	2,604	24	172,279	102	6,748		6
7	35	Rent-Equipment & Vehicles	Beds	2,604	24	122,579	102	4,801		7
8	36	Other	Beds	2,604	24		102			8
9	38	Medically Nec Transportation	Beds	2,604	24		102			9
10	39	Ancillary Service Centers	Beds	2,604	24		102			10
11	40	Barber and Beauty Shops	Beds	2,604	24		102			11
12	41	Coffee and Gift Shops	Beds	2,604	24		102			12
13	42	Other	Beds	2,604	24		102			13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 794,529	\$		\$ 31,122	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**					Purpose of Loan	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			\$	\$			\$ 104,058	1					
2	Bank of America		x	Loan Fee Amortization							5,903	2					
3												3					
4												4					
5												5					
Working Capital																	
6	Bank of America		x	Working Capital							18,990	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$			\$ 128,951	9					
B. Non-Facility Related*																	
10	Interest Income										(21,039)	10					
11												11					
12	Allocated Corporate										435	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (20,604)	14					
15	TOTALS (line 9+line14)						\$	\$			\$ 108,347	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 2012 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.)		\$	71,673		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	71,673		3	
4. Real Estate Tax accrual used for 2013 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.		\$	71,673		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	73,980	11			
	2012	71,673	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0048900

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1504279009</u>	_____	\$ 68,523.00	\$ 68,523.00
2. <u>1504278012</u>	_____	\$ 226.00	\$ 226.00
3. <u>1504279015</u>	_____	\$ 2,924.00	\$ 2,924.00
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>71,673.00</u>	\$ <u>71,673.00</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? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

Facility Name & ID Number Heritage Health-Litchfield

0048900 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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>6,816</u>	1
2					2
3	TOTALS			\$ <u>6,816</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	102			\$ 3,364,350	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Symmons Mixing Valve		1997	2,000					
10	Boiler		1997	5,612					
11	Dinning Room Roof Repair		1997	2,755					
12	Roof Repair		1997	3,280					
13									
14	Laundry Room Central Air		1996	3,019					
15	Heritage Manor Sign		1996	2,173					
16									
17	Roof		1998	60,674					
18	Booster Heater		1998	1,717					
19	Heat/Cool Units		1998	3,433					
20	Garbage Disposal		1998	730					
21									
22									
23									
24									
25									
26			1999	920					
27	Recirculating Pump		1999	2,046					
28	Plumbing repairs/Replacement		1999	10,045					
29	Carpet		1999	2,335					
30	Interior Painting--Materials and Labor								
31	Water Heater								
32									
33	C/O Allocation				19,138		19,138		
34	Book Depreciation				165,911		165,911		
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	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 Rooftop A/C Unit	2000	\$ 3,348	\$		\$	\$	\$
38 Blacktop Walkway	2000	2,250					
39 Gazebo	2000	7,675					
40							
41 A/C Unit	2001	3,879					
42 Gazebo	2001	981					
43							
44 A/C Unit	2002	1,453					
45 A/C Unit	2002	3,120					
46 Disposal	2002	794					
47 Boiler	2002	1,453					
48							
49 A/C Unit	2003	3,458					
50 A/C Unit	2003	833					
51 A/C Unit	2003	2,440					
52 A/C Unit	2003	4,542					
53 Food Processor	2003	1,227					
54 Ansul System	2003	1,271					
55							
56 Heat/Cool Units	2004	7,437					
57 Resurface Parking Lot	2004	30,570					
58 Roof Repair	2004	6,110					
59 Rooftop A/C Unit	2004	3,479					
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70 TOTAL (lines 4 thru 69)		\$ 3,551,409	\$ 185,049		\$ 185,049	\$	\$

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,551,409	\$ 185,049		\$ 185,049	\$	\$	1
2	Disposal	2005	842						2
3	Electrical Service	2005	8,421						3
4	A/C Units	2005	5,786						4
5	Boiler	2005	3,863						5
6	Exterior Lights	2005	1,095						6
7	Interior Remodel-- paint, wallcoverings	2005	49,155						7
8	Roof	2005	70,055						8
9	Exterior Door	2005	1,158						9
10	adjustments	2005	(4,948)						10
11	Storage Tank Replacement	2006	2,474						11
12	A/C Units	2006	13,308						12
13	Sidewalk	2006	4,566						13
14	A/C Units	2006	1,250						14
15	Exterior Door	2006	30						15
16	Roof	2006	98,093						16
17	adjustments	2006	(13,947)						17
18	HVAC	2007	6,631						18
19	Boiler	2007	1,363						19
20	Fire Panel	2007	2,007						20
21	Corridor Rehab --Paint	2007	32,114						21
22	Rheem Storage Tank	2007	3,422						22
23	Front Entry Doors	2007	4,450						23
24	Fire System	2007	6,769						24
25	Nurse Call	2007	2,565						25
26	Asbestos	2007	253						26
27	adjustments	2007	(6,680)						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,845,504	\$ 185,049		\$ 185,049	\$	\$	34

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	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		\$ 3,845,504	\$ 185,049		\$ 185,049	\$	\$	1
2	Corridor Rehab-- Paint	2008	11,629						2
3	Electrical Panel	2008							3
4	A/C -- Kitchen & Conf Room	2008	6,660						4
5	HVAC Boiler	2008	11,252						5
6	Exterior Rehab	2008	3,155						6
7	Nurse Call	2008	2,688						7
8	Landscaping	2008							8
9	Siding Laundry	2008	25,650						9
10	Sprinkler	2008	25,062						10
11									11
12	Resident Rm Remodel:paint, flooring & labor	2009	230,727						12
13	Backflow Preventor	2009	5,980						13
14	Windows	2009	38,840						14
15	Sprinkler system	2009	9,386						15
16	Nurse Call	2009	239,661						16
17									17
18	Resident Rm Remodel:paint, flooring & labor	2010	14,010						18
19	Generator	2010	17,868						19
20	Water Softener	2010	4,500						20
21									21
22	Air Conditioner	2011	4,680						22
23	Asphalt	2011	3,276						23
24	Water Heater	2011	13,603						24
25	Sign	2011	4,025						25
26	Exterior Windows	2011	40,675						26
27									27
28	Lighting Upgrade	2012	4,555						28
29	Computer Data Interface	2012	4,818						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,568,204	\$ 185,049		\$ 185,049	\$	\$	34

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

Facility Name & ID Number Heritage Health-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,568,204	\$ 185,049		\$ 185,049	\$	\$	1
2									2
3	Drain Line Replacement	2013	5,725						3
4	PTAC's	2013	7,655						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,581,584	\$ 185,049		\$ 185,049	\$	\$	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	\$ 799,099	\$ 60,570	\$ 60,570	\$		\$	71
72	Current Year Purchases	4,072						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 803,171	\$ 60,570	\$ 60,570	\$		\$	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)	\$ 5,391,571	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 245,619	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 245,619	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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 10,374 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Health-Litchfield # 0048900 Report Period Beginning: 01/01/13 Ending: 12/31/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 251,790	\$		\$ 251,790	1
2	Licensed Speech and Language Development Therapist		hrs				96,366			96,366	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				231,896	2,322		234,218	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					303,404		303,404	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						31,846			31,846	13
14	TOTAL			\$			\$ 611,898	\$ 305,726		\$ 917,624	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-Litchfield# 0048900Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,132	\$	1
2	Cash-Patient Deposits	4,190		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	914,239		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,670		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(294,257)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 664,974	\$	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)	\$ 664,974	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 207,876	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,190		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,678		30
31	Accrued Taxes Payable (excluding real estate taxes)	(168)		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>	66,509		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 483,085	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 483,085	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 181,889	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 664,974	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,283	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,283	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	172,606	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)	\$ 172,606	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)	\$ 181,889	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	\$ 4,378,771	1
2	Discounts and Allowances for all Levels	(1,950,918)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,427,853	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,934,955	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,934,955	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	443	12
13	Barber and Beauty Care	14,516	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	592,219	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	190	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 607,368	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	21,039	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,039	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,991,215	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	772,470	31
32	Health Care	2,507,895	32
33	General Administration	1,048,713	33
B. Capital Expense			
34	Ownership	476,124	34
C. Ancillary Expense			
35	Special Cost Centers	13,407	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,818,609	40
41	Income before Income Taxes (line 30 minus line 40)**	172,606	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 172,606	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-Litchfield

0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,800	2,024	\$ 58,181	\$ 28.75	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	5,128	5,540	156,992	28.34	3
4	Licensed Practical Nurses	19,176	21,006	425,646	20.26	4
5	CNAs & Orderlies	53,940	59,781	715,647	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			(204)		8
9	Activity Director					9
10	Activity Assistants	2,847	3,082	39,016	12.66	10
11	Social Service Workers	3,195	3,439	57,188	16.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,980	15,309	171,046	11.17	15
16	Dishwashers					16
17	Maintenance Workers	3,502	3,775	53,567	14.19	17
18	Housekeepers	9,862	10,849	102,632	9.46	18
19	Laundry	4,712	5,151	43,631	8.47	19
20	Administrator	1,900	2,080	93,956	45.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,304	4,735	92,078	19.45	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)	124,346	136,771	\$ 2,009,376 *	\$ 14.69	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	28,566		36
37	Medical Records Consultant	1,661		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,120		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	1,563		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 37,910		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	0		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	\$		53

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-Litchfield# 0048900

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,845
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ 2,253
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	1,132				1,009	1,009 PETTY C 1,132
1010	CASH IN BANK					1,100	1,100 ACCTS R 914,239
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	914,239				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 39,670
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	39,670				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 AI 0
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM] 0
1475	BUILDING & IMPROVEMEN	0				1,530	1,530 RESIDEN 4,190
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	4,190				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (294,257)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (207,876)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-294,257				2,100	2,100 ACCRUE (75,645)
2010	ACCOUNTS PAYABLE	-207,876				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-75,645				2,110	2,110 ACCRUE (129,033)
2110	ACCRUED VACATION PAY	-129,033				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	168
2125	FICA TAX PAYABLE	168	168	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 RE	
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 GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(66,509)
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-66,509		2,400	2,400 CURRENT PORTION OF LT DE	
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(4,190)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	0
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 DE	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	(9,283)
2460	INCOME TAXES PAYABLE				net income	(172,606)
2512	DUE TO RESIDENTS	-4,190				
2600	MORTGAGE PAYABLE	0				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-9,283				
2970	PROFIT/LOSS FOR PERIOD	-172,606				
3007.1	PATIENT DAYS-PRIVATE	7,218				3,007

3007.2	PATIENT DAYS-IPA	15,156						3,007
3007.3	PATIENT DAYS-MEDICARE	3,836						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 &	-4,339,633	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-32,776	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	-592,219	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,934,955	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	1,950,918	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	-14,516		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-443		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-6,362		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	-190		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	85,376	92,078	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	93,956	93,956	17	1	0	0		4,120
4115	VACATION & SICK - G&A	6,702		21	1	0	0		4,125
4120 4475	EMPLOYEE BENEFITS	8,549	454,686	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP	0		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	20,268	20,268	21	2	0	0		4,275
4260	TELEPHONE	9,612	9,612	21	3	0	0 **		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	5,973	5,973	23	3	16	0		4,280
4280	GENERAL TRAVEL	2,726	5,961	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	113		24	3	19	0 ***		4,285
4285	EDUCATION & SEMINAR	3,122		24	3	19	-11,113		4,289
4290	HELP WANTED ADVERTISING	1,524	84,160	20	3	0	0 -55,845		4,290
4291	PROMOTIONAL ADVERTISING	7,532		20	3	25	-7,532		4,291
4292	PUBLIC RELATIONS	6,325		20	3	25	-6,325		4,292
4300	LICENSES & FEES	61,359		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	6,538		20	3	17	-642		4,310
4320	CONTRIBUTIONS	25		27	3	20	0		4,320
4350	PROFESSIONAL FEES	3,640	218,109	19	3	22	-3,640		4,350
4355	MEDICAL DIRECTOR	28,566	28,566	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	1,661		10	3	0	0	4,364
4363	PHARMACIST FEES	6,120		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	1,563	1,563	12	3	0	0	4,383
4370	TV RENTAL	6,459		35	3	5	0	4,390
4380	INCOME TAXES		19,025	27	3	26	0	4,400
4383	BACKGROUND CHECKS	882		20	3	26	0	4,401
4400	PAYROLL TAXES	186,140		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	9,343		22	3	0	0	4,420
4410	GROUP INSURANCE	205,417		22	3	0	0	4,430
4420	LIABILITY INSURANCE	44,885	44,885	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	45,237		22	3	0	0 **	4,450
4450	CENTRAL OFFICE FEES	214,469		19	3	34	0	4,460
4460	BAD DEBTS	19,000		27	3	24	-19,000	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	3,915	10,374	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	48,661	53,567	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,906		6	1	0	0	4,510
5130	ELECTRIC	40,120	84,625	5	3	0	0	4,600
5131	NATURAL GAS	20,606		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	23,899		5	3	0	0	5,130
5134	TRASH COLLECTION	8,737	47,183	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	11,795	44,505	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	32,710		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	38,446		6	3	0	0	5,140
5210	DIETARY WAGES	157,577	171,046	1	1	0	0	5,160
5220	DIETARY SICK & VAC	13,469		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	176,522	174,269	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,683	9,303	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	758		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	5,862		1	2	0	0	5,260
5295	MEAL CREDIT	-2,253		2	2	0	0	5,270
5310	LAUNDRY WAGES	40,364	43,631	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,267		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	921	16,856	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	15,935		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	93,748	102,632	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	8,884		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	10,727	24,853	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	14,126		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,356,262	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	141,834		10	1	0	0	6,020
6030	DON WAGES	58,181		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	15,158		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	393,406		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	32,240		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	658,059		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	57,588		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 W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	-204		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	37,333	98,119	10	2	0	0	7,281
6295	NURSING SUPPLIES	60,433		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	353		10	2	0	0	7,391
6490	NURSING OTHER	642	8,423	10	3	0	0 ***	7,393
7280	DRUG PURCHASES	125,956	305,726	39	2	0	0	7,510
7281	DRUG PURCHASES-OTHER	177,448		39	2			7,540
7380	LABORATORY SERVICES	31,846	611,898	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	34,271	39,016	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,745		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	1,134	1,134	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	231,896		39	3	0	0	7,890
7660	PT SUPPLIES	2,322		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	53,946	57,188	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	3,242		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0 ***	8,130
7740	OT FEE	251,790		39	3	0	0	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0 ***	9,510
7770	SPEECH THERAPY FEE	96,366		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	12,673	12,673	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	734	734	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	446,760	446,760	34	3	0	0	

8120	INTEREST EXPENSE	18,990	18,990	32	3	14	-21,039
8130	DEPRECIATION	0	0	30	3	9	0
8150	LOAN FEE AMORTIZATION	0		32	3	0	0
9510	INTEREST INCOME	-21,039		32	0	10	0
9520	MISC NON-OPERATING INC	0		0	0	0	0
9700	INCOME TAXES	0		0	0	0	0
		4,797,570	4,818,609				
			21,039				

GRAND TOTALS -172,606 -69,291
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP 7,218

7,218

IPA 15,156

15,156

medicare 3,836

3,836

26,210

IPA BEDHOLDS 0

PP BEDHOLDS 0

PP CONVERS 0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT	15,156
3,007 PATIENT	3,836
	0

3,010 BASIC CH	(4,339,633)
3,020 BASIC CH	0
3,030 BASIC CH	0
	0
	0
	0
	0

3,080 NURSING	(32,776)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(592,219)
	0

3,110 PHYSICAL	(1,934,955)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

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

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHE	0
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3,411 MEDICAR	0
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3,420 MEDICAR	1,874,763
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3,520 RENT INC	0
3,530 BEAUTY :	(14,516)
	0
3,570 VENDING	(443)
3,590 EQUIPME	(6,362)
3,595 RESIDENT	0
3,600 MISC INC	(190)
4,110 G&A WAC	85,376
4,111 ADMINIS'	93,956
4,115 G&A PTO	6,702
4,120 EMPLOYE	8,544
4,130 EMPLOYE	0
4,135 EMPLOYE	0
4,250 OFFICE SI	6,372
4,255 POSTAGE	2,541
4,260 TELEPHO	9,612
4,275 TRAINING	5,973
	0
4,280 GENERAL	2,726
4,281 MEAL EX	113
4,285 EDUCATI	3,122
4,289 MEETING	0
4,290 HELP WA	1,524
4,291 PROMOTI	7,532
4,292 PUBLIC R	6,325
4,300 LICENSE	61,359
4,310 DUES & S	6,538
4,320 CONTRIB	25
4,350 PROFESSI	3,640
4,355 MEDICAL	28,566
	1,661
	6,120

4,364 SOCIAL S	1,563
4,370 TV RENTL	6,459
4,383 BACKGR	882
4,390 OTHER T	0
4,400 PAYROLL	186,140
4,401 PAYROLL	9,343
4,410 GROUP IN	205,417
4,420 LIABILIT	44,885
4,430 WORKMA	44,593
4,435 W/C-FIRS	176
4,436 DRUG TE	468
4,450 MANAGE	214,469
4,460 BAD DEB'	19,000
4,461 BAD DEB'	76,155
4,470 LOST ITE	0
4,475 UNIFORM	5
4,486 SERVICE	20,142
4,490 MISC EXP	118
4,496 MISC. M.I	11,355
4,510 REAL EST	0
4,600 LEASED F	3,915
5,110 MAINTEN	48,661
5,120 MAINTEN	4,906
5,130 ELECTRIC	40,120
5,131 NATURAL	20,606
5,133 WATER &	23,899
5,134 TRASH CO	8,737
5,140 PROP/PLA	11,795
5,160 GENERAL	32,710
5,165 MAINTEN	18,304
5,210 DIETARY	157,577
5,220 DIETARY	13,469
5,248 FOOD PUI	176,404

5,250 SUPPLIES	2,683
5,260 REPLACE	758
5,270 KITCHEN	5,862
5,295 MEAL INC	(2,253)
5,310 LAUNDRY	40,364
5,340 LAUNDRY	3,267
5,370 REPLACE	921
	0
5,390 SUPPLIES	15,935
5,410 HOUSEKE	93,748
5,440 HOUSEKE	8,884
5,480 SUPPLIES	10,727
5,490 SUPPLIES	14,126
6,020 RN WAGE	141,834
6,030 DON WAG	58,181
6,035 ADON WA	0
6,040 RN PTO &	15,158
6,120 LPN WAG	393,406
6,140 LPN PTO	32,240
6,220 AIDES WA	658,059
6,240 AIDES PT	57,588
	0
	0
	0
	0
6,270 REHAB W	0
6,275 REHAB P	(204)
6,290 NURSING	37,333
6,295 NURSING	60,433
6,390 REPLACE	353
6,490 OTHER	642

7,280 DRUG PU	125,956
7,281 DRUG PU	177,448
7,380 LABORA	14,694
7,390 X-RAY SE	15,383
	1,769
7,510 ACTIVITI	34,271
7,540 ACTIVITI	4,745
7,590 ACTIVITI	1,134
7,620 PHYSICAL	231,896
7,660 P.T. SUPP	2,322
7,710 SOCIAL S	53,946
7,720 SOCIAL S	3,242
7,730 SOCIAL S	0
7,740 OCCUPA	251,790
7,770 SPEECH T	96,366
7,820 BEAUTIC	12,673
	734
	0
8,120 INTEREST	0
	18,990
8,130 DEPRECL	0
	0
9,510 INTEREST	(21,039)
9,520 MISC NOI	0
4,220	0
8,100	446,760
9,702	0
5,230	0
	<u>(172,606)</u>

Expenses Fixed Assets

Related Parties
From Page 6

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