FOR BHF USE

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

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

I. IDPH License ID Number: 0048868

Facility Name: Heritage Health-Chillicothe

Address: 1028 Hillcrest Drive (Number) Chillicothe (City) 61523 (Zip Code)

County: Peoria

Telephone Number: (309) 274-2194 **Fax #** (   )

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

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

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	David M. Underwood
	(Title)	Sr. VP & CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone)	( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 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	110	Skilled (SNF)	110	40,150	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	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,109	7,234	4,898	33,241	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,109	7,234	4,898	33,241	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.79%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ____________ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified ____________ and days of care provided 4,898

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: ____________ Fiscal Year: ____________

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 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	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	244,224	15,059		259,283		259,283	7,752	267,035			1
2	Food Purchase		225,156		225,156		225,156	34	225,190			2
3	Housekeeping	111,414	26,359		137,773		137,773	4	137,777			3
4	Laundry	38,622	16,739		55,361		55,361		55,361			4
5	Heat and Other Utilities			78,546	78,546		78,546	1,702	80,248			5
6	Maintenance	73,889	76,432	58,143	208,464		208,464	16,827	225,291			6
7	Other (specify):*											7
8	**TOTAL General Services**	468,149	359,745	136,689	964,583		964,583	26,319	990,902			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,786,374	133,828	110,547	2,030,749		2,030,749	3,003	2,033,752			10
10a	Therapy		561,775	593,457	1,155,232	(608,882)	546,350		546,350			10a
11	Activities	68,329	7,800		76,129		76,129		76,129			11
12	Social Services	37,862		3,002	40,864		40,864		40,864			12
13	CNA Training	(60)	238		178		178	649	827			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,892,505	703,641	719,006	3,315,152	(608,882)	2,706,270	3,652	2,709,922			16
	C. General Administration											
17	Administrative	64,000			64,000		64,000		64,000			17
18	Directors Fees											18
19	Professional Services			276,529	276,529		276,529	(253,129)	23,400			19
20	Dues, Fees, Subscriptions & Promotions			163,475	163,475	(60,225)	103,250	(55,502)	47,748			20
21	Clerical & General Office Expenses	209,143	27,246	19,744	256,133		256,133	321,586	577,719			21
22	Employee Benefits & Payroll Taxes			546,652	546,652		546,652	48,794	595,446			22
23	Inservice Training & Education			7,837	7,837		7,837	653	8,490			23
24	Travel and Seminar			16,139	16,139		16,139	(14,140)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,045	58,045		58,045	12,186	70,231			26
27	Other (specify):*			10,324	10,324		10,324	(6,000)	4,324			27
28	**TOTAL General Administration**	273,143	27,246	1,098,745	1,399,134	(60,225)	1,338,909	54,448	1,393,357			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,633,797	1,090,632	1,954,440	5,678,869	(669,107)	5,009,762	84,419	5,094,181			29

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

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

Facility Name & ID Number **Heritage Health-Chillicothe** **#0048868** **Report Period Beginning:** **01/01/13** **Ending:** **12/31/13**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							253,448	253,448			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,788	22,788		22,788	119,991	142,779			32
33	Real Estate Taxes							73,069	73,069			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(474,522)	7,278			34
35	Rent-Equipment & Vehicles			7,920	7,920		7,920	5,178	13,098			35
36	Other (specify):*											36
37	**TOTAL Ownership**			512,508	512,508		512,508	(22,836)	489,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					608,882	608,882	(41,393)	567,489			39
40	Barber and Beauty Shops			7,044	7,044		7,044		7,044			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,225	60,225		60,225			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			7,044	7,044	669,107	676,151	(41,393)	634,758			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,633,797	1,090,632	2,473,992	6,198,421		6,198,421	20,190	6,218,611			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-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(29,011)			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	(488)			17
18	Fines and Penalties				18
19	Entertainment	(21,851)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,901)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(66,318)			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)**	$ (127,569)		$	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)	147,759		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 147,759		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 20,190		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

STATE OF ILLINOIS

Heritage Health-Chillicothe

ID# 0048868

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		(488)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,901)	19	22
23				23
24		(6,000)	27	24
25		(66,318)	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**	(76,707)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	7,752	0	0	0	0	0	0	0	0	7,752	1
2	Food Purchase	0	0	34	0	0	0	0	0	0	0	0	34	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	1,702	0	0	0	0	0	0	0	0	1,702	5
6	Maintenance	0	0	16,827	0	0	0	0	0	0	0	0	16,827	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	26,319	0	0	0	0	0	0	0	0	26,319	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	3,003	0	0	0	0	0	0	0	0	3,003	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	649	0	0	0	0	0	0	0	0	649	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	3,652	0	0	0	0	0	0	0	0	3,652	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	(3,901)	(270,833)	21,605	0	0	0	0	0	0	0	0	(253,129)	19
20	Fees, Subscriptions & Promotions	(66,806)	0	11,304	0	0	0	0	0	0	0	0	(55,502)	20
21	Clerical & General Office Expenses	0	0	321,586	0	0	0	0	0	0	0	0	321,586	21
22	Employee Benefits & Payroll Taxes	0	0	48,794	0	0	0	0	0	0	0	0	48,794	22
23	Inservice Training & Education	0	0	653	0	0	0	0	0	0	0	0	653	23
24	Travel and Seminar	(21,851)	0	7,711	0	0	0	0	0	0	0	0	(14,140)	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	12,186	0	0	0	0	0	0	0	0	12,186	26
27	Other (specify):*	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	27
28	**TOTAL General Administration**	(98,558)	(270,833)	423,839	0	0	0	0	0	0	0	0	54,448	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(98,558)	(270,833)	453,810	0	0	0	0	0	0	0	0	84,419	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	0	232,809	0	20,639	0	0	0	0	0	0	0	253,448	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,011)	148,533	0	469	0	0	0	0	0	0	0	119,991	32
33	Real Estate Taxes	0	73,069	0	0	0	0	0	0	0	0	0	73,069	33
34	Rent-Facility & Grounds	0	(481,800)	0	7,278	0	0	0	0	0	0	0	(474,522)	34
35	Rent-Equipment & Vehicles	0	0	0	5,178	0	0	0	0	0	0	0	5,178	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,011)	(27,389)	0	33,564	0	0	0	0	0	0	0	(22,836)	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	(41,393)	0	0	0	0	0	0	0	0	0	(41,393)	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	(41,393)	0	0	0	0	0	0	0	0	0	(41,393)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(127,569)	(339,615)	453,810	33,564	0	0	0	0	0	0	0	20,190	45

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Pg 25				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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
2	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(41,393)	(41,393)	2
3	V								3
4	V	19	Adjustment for Related Organization	270,833	Heritage Operations Group, LLC	0.00%		(270,833)	4
5	V								5
6	V	34	Adjustment for Related Organization	481,800	Heritage Manor Real Estate, LLC	0.00%		(481,800)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		73,069	73,069	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		142,783	142,783	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		232,809	232,809	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,750	5,750	10
11	V								11
12	V								12
13	V								13
14	Total			$ 752,633			$ 413,018	$ * (339,615)	14

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 7,752	15
16	V	2	Food Purchase					34	16
17	V	3	Housekeeping					4	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,702	19
20	V	6	Maintenance					16,827	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					3,003	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					649	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					21,605	31
32	V	20	Fees, Subscription, Promotions					11,304	32
33	V	21	Clerical & General Office Expenses					321,586	33
34	V	22	Employee Benefits & Payroll Taxes					48,794	34
35	V	23	Inservice Training & Education					653	35
36	V	24	Travel and Seminar					7,711	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,186	38
39	Total			$			$ 0	$ * 453,810	39

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$	$	15
16	V	30	Depreciation					20,639	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					469	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					7,278	20
21	V	35	Rent-Equipment & Vehicles					5,178	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	$ * 33,564	39

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,604	24	$ 183,508	$ 183,106	110	$ 7,752	1
2	2	Food Purchase	Beds	2,604	24	798	0	110	34	2
3	3	Housekeeping	Beds	2,604	24	106	0	110	4	3
4	4	Laundry	Beds	2,604	24	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,604	24	40,282	0	110	1,702	5
6	6	Maintenance	Beds	2,604	24	398,350	84,311	110	16,827	6
7	7	Other	Beds	2,604	24	0	0	110	0	7
8	9	Medical Director	Beds	2,604	24	0	0	110	0	8
9	10	Nursing & Medical Records	Beds	2,604	24	71,096	69,815	110	3,003	9
10	11	Activities	Beds	2,604	24	0	0	110	0	10
11	12	Social Service	Beds	2,604	24	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,604	24	15,364	15,279	110	649	12
13	14	Program Transportation	Beds	2,604	24	0	0	110	0	13
14	15	Other	Beds	2,604	24	0	0	110	0	14
15	17	Administrative	Beds	2,604	24	0	0	110	0	15
16	18	Directors Fees	Beds	2,604	24	0	0	110	0	16
17	19	Professional Services	Beds	2,604	24	511,456	0	110	21,605	17
18	20	Fees, Subscription, Promotions	Beds	2,604	24	267,591	0	110	11,304	18
19	21	Clerical & General Office Expens	Beds	2,604	24	7,612,820	7,140,260	110	321,586	19
20	22	Employee Benefits & Payroll Tax	Beds	2,604	24	1,155,097	0	110	48,794	20
21	23	Inservice Training & Education	Beds	2,604	24	15,452	0	110	653	21
22	24	Travel and Seminar	Beds	2,604	24	182,552	0	110	7,711	22
23	25	Other Admin. Staff Transportatio	Beds	2,604	24	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,604	24	288,473	0	110	12,186	24
25	TOTALS					$ 10,742,945	$ 7,492,771		$ 453,810	25

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,604	24	$	$	110	$	1
2	30	Depreciation	Beds	2,604	24	488,578		110	20,639	2
3	31	Amortization of Pre-Op & Org	Beds	2,604	24			110		3
4	32	Interest	Beds	2,604	24	11,093		110	469	4
5	33	Real Estate Taxes	Beds	2,604	24			110		5
6	34	Rent-Facility & Grounds	Beds	2,604	24	172,279		110	7,278	6
7	35	Rent-Equipment & Vehicles	Beds	2,604	24	122,579		110	5,178	7
8	36	Other	Beds	2,604	24			110		8
9	38	Medically Nec Transportation	Beds	2,604	24			110		9
10	39	Ancillary Service Centers	Beds	2,604	24			110		10
11	40	Barber and Beauty Shops	Beds	2,604	24			110		11
12	41	Coffee and Gift Shops	Beds	2,604	24			110		12
13	42	Other	Beds	2,604	24			110		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	$		$ 33,564	25

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	Busey Bank		x	Mortgage			$	$ 3,137,976			$ 142,783	1
2	Busey Bank		x	Loan Fee Amortization							5,750	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							22,788	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,137,976			$ 171,321	9
	B. Non-Facility Related*											
10	Interest Income										(29,011)	10
11												11
12	Allocated Corporate										469	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (28,542)	14
15	TOTALS (line 9+line14)						$	$ 3,137,976			$ 142,779	15

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

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

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)	$	73,069	2
3. Under or (over) accrual (line 2 minus line 1).	$	73,069	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.	$	73,069	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011	74,372	11
2012	73,069	12

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2012	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Chillicothe COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0048868

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0529376016		$ 71,831.00	$ 71,831.00
2.	0529376017		$ 1,195.00	$ 1,195.00
3.	0529380001		$ 43.00	$ 43.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,069.00	$ 73,069.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? __________ YES __________ 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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 [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

none

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

1. Total Amount Incurred: ______ 2. Number of Years Over Which it is Being Amortized: ______

3. Current Period Amortization: ______ 4. Dates Incurred: ______

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$ 129,000	1
2					2
3	TOTALS			$ 129,000	3

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110				$ 3,301,403	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Awning			1998	2,334						9
10	Heritage Sign			1998	1,860						10
11	Chiller Replacement			1998	54,444						11
12											12
13	Interior Remodel--Materials			1999	154,576						13
14				1999							14
15	Interior Remodel--Professional Fees			1999	24,247						15
16											16
17	Water Heater controls			2000	1,347						17
18	Water Heater			2000	57,254						18
19	Door Locks			2000	1,997						19
20	Heat / Cool Fan			2000	1,598						20
21	Fire Alarm System			2000	4,400						21
22	Alzheimer Unit -- Professional Fees			2000	25,115						22
23	Interior Remodel--Materials (see attached)			2000	93,951						23
24	Interior Remodel--Labor (see attached)			2000	23,130						24
25	Interior Remodel--Professional Fees (see attached)			2000	5,762						25
26											26
27	Water Softener			2001	4,246						27
28	Boiler			2001	29,350						28
29	Door Holders			2001	654						29
30	Alzheimer Unit -- Professional Fees			2001	4,660						30
31											31
32											32
33	C/O Allocation					20,639		20,639			33
34	Book Depreciation					196,212		196,212			34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet	2002	$ 2,373	$		$	$	$	37
38	Compressor	2002	1,164						38
39	Compressor	2002	7,234						39
40	Windows	2002	1,722						40
41									41
42	Storge Tank	2003	737						42
43	In-sink Aerator	2003	810						43
44	Boiler	2003	16,393						44
45	Carpet	2003	2,839						45
46									46
47	Smoke detectors	2004	2,285						47
48	Dinning Room Waitress	2004	2,617						48
49	Parking Lot Sealcoat	2004	4,926						49
50	Boiler Pipe	2004	3,775						50
51	Auto Trans Switch	2004	16,847						51
52	Day Room	2004	1,778						52
53									53
54	Day Room	2005	8,753						54
55	Boiler	2005	19,619						55
56	Fire Alarm	2005	1,628						56
57	Resident Room Carpet	2005	698						57
58	Security System	2005	6,393						58
59	Breaker Replacement	2005	1,980						59
60	Condenser	2005	1,118						60
61	Roof	2005	188,466						61
62	Wiring	2005	820						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,087,303	$ 216,851		$ 216,851	$	$	70

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,087,303	$ 216,851		$ 216,851	$	$	1
2	Heat pump	2006	5,669						2
3	Boiler	2006	72,981						3
4	fire Alarm	2006	3,553						4
5	Roof	2006	1,300						5
6	Kitchen remodel	2006	4,623						6
7	Carpet	2006	1,139						7
8	Condensing Unit	2006	2,000						8
9	East Wing Dinning Room Remodel	2006	5,228						9
10									10
11	East Wing Remodel-- paint, floors	2007	23,281						11
12	Boiler	2007							12
13	Fire Alarm	2007							13
14	Generator	2007							14
15	Code Alert	2007	4,622						15
16	Fence	2007	3,089						16
17	Landscapping	2007							17
18	Parking Lot sealer	2007	5,000						18
19	Generator	2007	8,260						19
20	Heat pump	2007	21,969						20
21	Water Line	2007							21
22									22
23	East Wing Remodel-- paint, floors	2008	61,290						23
24	Sprinkler Backflow	2008	4,360						24
25	Heat pump	2008	16,046						25
26	Soiled Utility/Med Room	2008	2,622						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,334,335	$ 216,851		$ 216,851	$	$	34

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,334,335	$ 216,851		$ 216,851	$	$	1
2									2
3	Window replacements	2009	64,129						3
4									4
5	HVAC	2009	6,180						5
6	Heat Pump	2009	26,052						6
7	Nurse Call system	2009	226,889						7
8									8
9	Chiller	2010	3,429						9
10	Data Equipment Relocation	2010	2,658						10
11	Roof	2010	129,751						11
12	Paint, flooring & Labor Dining Room	2010	7,567						12
13									13
14	Sprinkler system	2011	77,240						14
15	Coil Unit	2011	3,744						15
16	Fluid cooler	2011	40,567						16
17	Exhaust fans	2011	7,141						17
18	Concrete walkway	2011	10,067						18
19	Remodel Administror's office	2011	3,200						19
20	Sign	2011	19,723						20
21	Boiler	2011	13,577						21
22									22
23	Lighting Upgrade	2012	6,143						23
24	Boiler	2012	15,051						24
25									25
26	Boiler Replacement Final Payment	2013	3,132						26
27	Renovation Project Design	2013	12,052						27
28	Ceiling Replacement / Asbestos Removal	2013	65,282						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,077,909	$ 216,851		$ 216,851	$	$	34

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 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		$ 5,077,909	$ 216,851		$ 216,851	$	$	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,077,909	$ 216,851		$ 216,851	$	$	34

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 736,468	$ 36,597	$ 36,597	$		$	71
72	Current Year Purchases	9,005						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 745,473	$ 36,597	$ 36,597	$		$	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)	$ 5,952,382	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 253,448	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 253,448	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. YES NO

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

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

9. Option to Buy: YES NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: $ 7,920 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-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		238		238
3	Classroom Wages (a)				
4	Clinical Wages (b)		(60)		(60)
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 178	$	$ 178
10	SUM OF line 9, col. 1 and 2 (e)	$ 178			

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 213,740	$		$ 213,740	1
2	Licensed Speech and Language Development Therapist		hrs			44,681			44,681	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			285,834	2,095		287,929	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				559,680		559,680	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					49,202			49,202	13
14	TOTAL			$		$ 593,457	$ 561,775		$ 1,155,232	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-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,443	$	1
2	Cash-Patient Deposits	22,423		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	998,735		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,443		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(204,435)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 825,609	$	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)**	$ 825,609	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 231,696	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,423		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	265,971		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,935		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	Assessment Tax	87,329		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 613,354	$	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)**	$ 613,354	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 212,255	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 825,609	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 111,841	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 111,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,414	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)**	$ 100,414	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 212,255	24 *

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,678,311	1
2	Discounts and Allowances for all Levels	(2,217,672)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,460,639	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,780,185	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,780,185	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	(2,131)	12
13	Barber and Beauty Care	7,417	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,019,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,307	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,029,000	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29,011	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,011	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)**	$ 6,298,835	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	964,583	31
32	Health Care	3,315,152	32
33	General Administration	1,399,134	33
	B. Capital Expense		
34	Ownership	512,508	34
	C. Ancillary Expense		
35	Special Cost Centers	7,044	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)***	$ 6,198,421	40
41	**Income before Income Taxes (line 30 minus line 40)****	100,414	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 100,414	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-Chillicothe # 0048868 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	1,451	1,451	$ 48,013	$ 33.09	1
2	Assistant Director of Nursing	1,955	2,215	61,898	27.94	2
3	Registered Nurses	11,027	11,688	324,921	27.80	3
4	Licensed Practical Nurses	19,465	21,197	476,454	22.48	4
5	CNAs & Orderlies	63,050	66,501	800,385	12.04	5
6	CNA Trainees			(60)		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,414	4,009	74,703	18.63	8
9	Activity Director					9
10	Activity Assistants	5,333	5,604	68,329	12.19	10
11	Social Service Workers	2,212	2,467	37,862	15.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,781	21,561	244,224	11.33	15
16	Dishwashers					16
17	Maintenance Workers	3,482	3,829	73,889	19.30	17
18	Housekeepers	9,607	10,239	111,414	10.88	18
19	Laundry	3,703	4,074	38,622	9.48	19
20	Administrator	1,900	2,080	64,000	30.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,035	10,763	209,143	19.43	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)	156,415	167,678	$ 2,633,797 *	$ 15.71	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,671		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,002		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,273		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	131	$ 5,233		50
51	Licensed Practical Nurses	405	14,173		51
52	Certified Nurse Assistants/Aides	0	81,697		52
53	TOTAL (lines 50 - 52)	536	$ 101,103		53

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brandy Cooper			$ 64,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 270,833
McKee Environmental	Consulting	1,795
Legal adj to Zero		3,901
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 276,529

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,985
Unemployment Compensation Insurance	52,173
FICA Taxes	201,485
Employee Health Insurance	181,715
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	35,294
Central Office Allocation	48,794
TOTAL (agree to Schedule V, line 22, col.8)	$ 595,446

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,667
Health Care Worker Background Check	
(Indicate # of checks performed)	2,335
Patient Background Checks	
	20,438
Dues & Subscriptions	9,008
License & Fees	5,922
Central Office Allocation	11,304
Less: Public Relations Expense	(20,438)
Non-allowable advertising	(488)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	13,615
	354
Seminar Expense	2,170
	(14,140)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

Facility Name & ID Number **Heritage Health-Chillicothe** **# 0048868** **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. $ **60,225**
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. $ **2,066**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? **100%**

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg Line #	Sch 5 pg Col #	Sch 6 pg Line #	Adjustment Amount				
1009	PETTY CASH	1,443						1,009	1,009	PETTY C	1,443
1010	CASH IN BANK							1,100	1,100	ACCTS R	998,735
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	998,735						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	7,443
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	7,443						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 I	0
1475	BUILDING & IMPROVEMEN	0						1,530	1,530	RESIDEN	22,423
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FE	0
1530	RESIDENT FUNDS	22,423						1,551	1,551	LOAN FEES ADDED	
1550	LOAN FEES	0						1,850	1,850	INTERCC	(204,435)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	(231,696)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-204,435						2,100	2,100	ACCRUE	(138,466)
2010	ACCOUNTS PAYABLE	-231,696						2,100	2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-138,466						2,110	2,110	ACCRUE	(127,505)
2110	ACCRUED VACATION PAY	-127,505						2,120	2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-5,935	-5,935
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYA	0	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-87,329	
2350	REAL ESTATE TAX PAYAB	0	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-22,423	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-111,841	
2970	PROFIT/LOSS FOR PERIOD	-100,414	
3007.1	PATIENT DAYS-PRIVATE	7,234	

2,125	2,125	FICA TA	(5,935)
2,130	2,130	FEDERAL W/H TAX PAYABLI	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE RE	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETI	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNISHMENT	
2,300	2,300	ACCRUE	0
2,320	2,320	IPA PAYI	(87,329)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DI	
2,512	2,512	DUE TO I	(22,423)
2,600	2,600	LASALLI	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DI	
2,720	2,720	RETAINE	(111,841)
		net incom	(100,414)
		balance	0
			3,007

3007.2		PATIENT DAYS-IPA	21,109					3,007
3007.3		PATIENT DAYS-MEDICARE	4,898					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 &	-5,646,064	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	-29,387	0	0	0	0	3,081
3081	1	NURSING SUPPLIES-IPA		0	0	0	0	3,082
3082	1	NURSING SUPPLIES MED PT A		0	0	0	0	3,083
3083	1	NURSING SUPPLIES MED PT B						3,100
3100	17	DRUGS	-1,019,407	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-1,780,185	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	2,217,672	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	-7,417		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPEN!	2,131		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-2,860		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	-3,762		0	0	0	0			4,110
3600		21	MISC INCOME	-545		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	198,855	209,143	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	64,000	64,000	17	1	0	0			4,120
4115			VACATION & SICK - G&A	10,288		21	1	0	0			4,125
4120	4475		EMPLOYEE BENEFITS	17,851	546,652	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VA(	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP	12,633		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP	4,810		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	27,246	27,246	21	2	0	0			4,275
4260			TELEPHONE	19,744	19,744	21	3	0	0	**		4,276
4275			TRAINING & EMPLOYEE D	7,837	7,837	23	3	16	0			4,280
4280			GENERAL TRAVEL	13,615	16,139	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	354		24	3	19	0	***		4,285
4285			EDUCATION & SEMINAR	2,170		24	3	19	-21,851			4,289
4290			HELP WANTED ADVERTISI	19,667	163,475	20	3	0	0		-60,225	4,290
4291			PROMOTIONAL ADVERTIS	45,880		20	3	25	-45,880			4,291
4292			PUBLIC RELATIONS	20,438		20	3	25	-20,438			4,292
4300			LICENSES & FEES	66,147		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	9,008		20	3	17	-488			4,310
4320			CONTRIBUTIONS	100		27	3	20	0			4,320
4350			PROFESSIONAL FEES	5,696	276,529	19	3	22	-3,901			4,350
4355			MEDICAL DIRECTOR	12,000	12,000	9	3	0	0			4,355
4360			UTILIZATION REVIEW	0		10	3	0	0			4,362
4361			OTHER PHYSICIAN FEES			39	3	0	0			4,363

4362	MEDICAL RECORDS CONSU	2,671		10	3	0	0	4,364
4363	PHARMACIST FEES	6,600		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,002	3,002	12	3	0	0	4,383
4370	TV RENTAL	2,941		35	3	5	0	4,390
4380	INCOME TAXES		10,324	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,335		20	3	26	0	4,401
4400	PAYROLL TAXES	247,015		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	6,643		22	3	0	0	4,420
4410	GROUP INSURANCE	181,715		22	3	0	0	4,430
4420	LIABILITY INSURANCE	58,045	58,045	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	75,985		22	3	0	0 **	4,450
4450	CENTRAL OFFICE FEES	270,833		19	3	34	0	4,460
4460	BAD DEBTS	6,000		27	3	24	-6,000	4,461
4470	LOST ITEMS-RESIDENTS	4,224		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	4,979	7,920	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	67,822	73,889	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	6,067		6	1	0	0	4,510
5130	ELECTRIC	45,968	78,546	5	3	0	0	4,600
5131	NATURAL GAS	19,146		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	13,432		5	3	0	0	5,130
5134	TRASH COLLECTION	9,895	58,143	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	26,751	76,432	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	49,681		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	48,248		6	3	0	0	5,140
5210	DIETARY WAGES	227,554	244,224	1	1	0	0	5,160
5220	DIETARY SICK & VAC	16,670		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	227,222	225,156	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,593	15,059	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	4,723		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,743		1	2	0	0	5,260
5295	MEAL CREDIT	-2,066		2	2	0	0	5,270
5310	LAUNDRY WAGES	36,537	38,622	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,085		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	10,575	16,739	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	6,164		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	104,370	111,414	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & V/	7,044		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	6,327	26,359	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	20,032		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,786,374	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	299,877		10	1	0	0	6,020
6030	DON WAGES	48,013		10	1	0	0	6,030
6035	ADON	61,898		10	1	0	0	6,035
6040	RN SICK & VACATION	25,044		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	446,367		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	30,087		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC/	768,669		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	31,716		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	5,233		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	14,173		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	81,697		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	-60	-60	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	238	238	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	69,860		10	1	0	0	6,390
6275	REHAB SICK & VAC	4,843		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0		7,280
6290	NURSING SUPPLIES	67,390	133,828	10	2	0	0		7,281
6295	NURSING SUPPLIES	61,798		10	2	0	0		7,380
6390	REPLACEMENT-NURSING	4,640		10	2	0	0		7,391
6490	NURSING OTHER	173	110,547	10	3	0	0	***	7,393
7280	DRUG PURCHASES	262,311	561,775	39	2	0	0		7,510
7281	DRUG PURCHASES-OTHER	297,369		39	2				7,540
7380	LABORATORY SERVICES	49,202	593,457	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	64,673	68,329	11	1	0	0		7,720
7540	ACTIVITIES SICK & VAC	3,656		11	1	0	0		7,730
7590	ACTIVITIES SUPPLIES	7,800	7,800	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	285,834		39	3	0	0		7,890
7660	PT SUPPLIES	2,095		39	2	0	0		7,960
7710	SOCIAL SERVICE WAGES	35,919	37,862	12	1	0	0		8,120
7720	SOCIAL SERVICE SICK & V	1,943		12	1	0	0		8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	***	8,130
7740	OT FEE	213,740		39	3	0	0		8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	***	9,510
7770	SPEECH THERAPY FEE	44,681		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	7,044	7,044	40	3	0	0		
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910	VOLUNTEER COORDINATOR			21	1	0	0		
7940	VOL COORD SICK & VAC			21	1	0	0		
7960	VOL COORD SUPPLIES	0		21	2	0	0		
8100	RENT	481,800	481,800	34	3	0	0		

8120	INTEREST EXPENSE	22,788	22,788	32	3	14	-29,011
8130	DEPRECIATION	0	0	30	3	9	0
8150	LOAN FEE AMORTIZATION	0		32	3	0	0
9510	INTEREST INCOME	-29,011		32	0	10	0
9520	MISC NON-OPERATING INC	0		0	0	0	0
9700	INCOME TAXES	0		0	0	0	0
		6,169,410	6,198,421				
			29,011				
GRAND TOTALS		-100,414					-127,569
		(NET INCOME)					
		0					
	FACILITY NAME:						
	FACILITY ID:	0					
	FACILITY UNITS:	110					
	BALANCE SHEET TOTAL	0					

	G/L	RECAP CENSUS
PP	7,234	7,234
IPA	21,109	21,109
medicare	4,898	4,898
		33,241

IPA BEDHOLDS	0
PP BEDHOLDS	0
PP CONVERS	0

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3,007 PATIENT 7,234

3,007	PATIENT	21,109
3,007	PATIENT	4,898
		0
3,010	BASIC CH	(5,646,064)
3,020	BASIC CH	0
3,030	BASIC CH	0
		0
		0
		0
		0
3,080	NURSING	(29,387)
3,081	NURSING	0
3,082	NURSING	0
3,083	NURSING	0
3,100	DRUGS-M	(1,019,407)
		0
3,110	PHYSICAL	(1,780,185)
		0
3,112	PHYSICAL	0
3,113	PHYSICAL	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTHE	0
3,411	MEDICAR	0
3,420	MEDICAR	2,114,953

3,520	RENT INC	0
3,530	BEAUTY :	(7,417)
		0
3,570	VENDING	2,131
3,590	EQUIPME	(2,860)
3,595	RESIDEN'	(3,762)
3,600	MISC INC	(545)
4,110	G&A WA(	198,855
4,111	ADMINIS'	64,000
4,115	G&A PTO	10,288
4,120	EMPLOYI	15,189
4,130	EMPLOYI	12,633
4,135	EMPLOYI	4,810
4,250	OFFICE S	15,198
4,255	POSTAGE	1,668
4,260	TELEPHO	19,744
4,275	TRAININ(	7,837
		(6)
4,280	GENERAL	13,615
4,281	MEAL EX	354
4,285	EDUCATI	1,565
4,289	MEETING	605
4,290	HELP WA	19,667
4,291	PROMOTI	45,880
4,292	PUBLIC R	20,438
4,300	LICENSE .	66,147
4,310	DUES & S	9,008
4,320	CONTRIB	100
4,350	PROFESSI	5,696
4,355	MEDICAL	12,000
		2,671
		6,600

4,364	SOCIAL S	3,002
4,370	TV RENT/	2,941
4,383	BACKGR(	2,335
4,390	OTHER T/	0
4,400	PAYROLI	247,015
4,401	PAYROLI	6,643
4,410	GROUP IN	181,715
4,420	LIABILIT	58,045
4,430	WORKMA	73,194
4,435	W/C-FIRS	266
4,436	DRUG TE	2,531
4,450	MANAGE	270,833
4,460	BAD DEB	6,000
4,461	BAD DEB	102,719
4,470	LOST ITE	4,224
4,475	UNIFORM	2,662
4,486	SERVICE	21,184
4,490	MISC EXI	89
4,496	MISC. M.I	10,380
4,510	REAL EST	0
4,600	LEASED I	4,979
5,110	MAINTEN	67,822
5,120	MAINTEN	6,067
5,130	ELECTRI(	45,968
5,131	NATURAI	19,146
5,133	WATER &	13,432
5,134	TRASH C(	9,895
5,140	PROP/PL/	26,751
5,160	GENERAI	49,681
5,165	MAINTEN	27,064
5,210	DIETARY	227,554
5,220	DIETARY	16,670
5,248	FOOD PUI	227,133

5,250	SUPPLIES	2,593
5,260	REPLACE	4,723
5,270	KITCHEN	7,743
5,295	MEAL INC	(2,066)
5,310	LAUNDRY	36,537
5,340	LAUNDRY	2,085
5,370	REPLACE	10,575
		0
5,390	SUPPLIES	6,164
5,410	HOUSEKE	104,370
5,440	HOUSEKE	7,044
5,480	SUPPLIES	6,327
5,490	SUPPLIES	20,032
6,020	RN WAGE	299,877
6,030	DON WAC	48,013
6,035	ADON WA	61,898
6,040	RN PTO &	25,044
6,120	LPN WAG	446,367
6,140	LPN PTO	30,087
6,220	AIDES WA	768,669
6,240	AIDES PT	31,716
		5,233
		14,173
		81,697
		(60)
		238
		0
6,270	REHAB W	69,860
6,275	REHAB PT	4,843
6,290	NURSING	67,390
6,295	NURSING	61,798
6,390	REPLACE	4,640
6,490	OTHER	173

7,280	DRUG PU	262,311
7,281	DRUG PU	297,369
7,380	LABORAT	21,504
7,390	X-RAY SE	6,139
		21,559
7,510	ACTIVITI	64,673
7,540	ACTIVITI	3,656
7,590	ACTIVITI	7,800
7,620	PHYSICAI	285,834
7,660	P.T. SUPP	2,095
7,710	SOCIAL S	35,919
7,720	SOCIAL S	1,943
7,730	SOCIAL S	0
7,740	OCCUPAT	213,740
7,770	SPEECH T	44,681
7,820	BEAUTIC	7,044
		0
		0
8,120	INTEREST	0
		22,788
8,130	DEPRECIA	0
		0
9,510	INTEREST	(29,011)
9,520	MISC NOI	0
4,220		0
8,100		481,800
9,702		0
5,230		0
		(100,414)

Expenses Fixed Assets

0

Related Parties
From Page 6

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