FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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) EVP & 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**

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,438	9,673	3,600	31,711	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,438	9,673	3,600	31,711	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.98%

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 3,600

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:** 01/01/15 **Ending:** 12/31/15

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	242,291	14,168		256,459		256,459	5,868	262,327			1
2	Food Purchase		219,433		219,433		219,433	34	219,467			2
3	Housekeeping	109,627	22,179		131,806		131,806	42	131,848			3
4	Laundry	45,573	13,906		59,479		59,479		59,479			4
5	Heat and Other Utilities			76,532	76,532		76,532	1,523	78,055			5
6	Maintenance	61,349	67,948	90,637	219,934		219,934	17,950	237,884			6
7	Other (specify):*											7
8	**TOTAL General Services**	458,840	337,634	167,169	963,643		963,643	25,417	989,060			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,902,639	160,022	90,579	2,153,240		2,153,240	(22,909)	2,130,331			10
10a	Therapy		523,293	744,270	1,267,563	(570,263)	697,300		697,300			10a
11	Activities	87,772	5,199		92,971		92,971		92,971			11
12	Social Services	31,612		2,661	34,273		34,273		34,273			12
13	CNA Training		2,749		2,749		2,749	1,045	3,794			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,022,023	691,263	849,510	3,562,796	(570,263)	2,992,533	(21,864)	2,970,669			16
	C. General Administration											
17	Administrative	80,000			80,000		80,000		80,000			17
18	Directors Fees											18
19	Professional Services			301,003	301,003		301,003	(272,852)	28,151			19
20	Dues, Fees, Subscriptions & Promotions			168,175	168,175	(60,225)	107,950	(50,307)	57,643			20
21	Clerical & General Office Expenses	202,491	25,002	14,195	241,688		241,688	351,166	592,854			21
22	Employee Benefits & Payroll Taxes			604,491	604,491		604,491	52,440	656,931			22
23	Inservice Training & Education			7,964	7,964		7,964	685	8,649			23
24	Travel and Seminar			14,571	14,571		14,571	(9,572)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,116	69,116		69,116	15,188	84,304			26
27	Other (specify):* **Lost Resident Items**			44,443	44,443		44,443	(43,566)	877			27
28	**TOTAL General Administration**	282,491	25,002	1,223,958	1,531,451	(60,225)	1,471,226	43,182	1,514,408			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,763,354	1,053,899	2,240,637	6,057,890	(630,488)	5,427,402	46,735	5,474,137			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: 01/01/15 Ending: 12/31/15

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							228,269	228,269			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,005	37,005		37,005	109,476	146,481			32
33	Real Estate Taxes							73,873	73,873			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(475,513)	6,287			34
35	Rent-Equipment & Vehicles			13,231	13,231		13,231	8,761	21,992			35
36	Other (specify):*											36
37	**TOTAL Ownership**			532,036	532,036		532,036	(55,134)	476,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					570,263	570,263	(43,515)	526,748			39
40	Barber and Beauty Shops			6,584	6,584		6,584		6,584			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**			6,584	6,584	630,488	637,072	(43,515)	593,557			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,763,354	1,053,899	2,779,257	6,596,510		6,596,510	(51,914)	6,544,596			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: 01/01/15 Ending: 12/31/15

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	(1,171)			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	(25)			17
18	Fines and Penalties				18
19	Entertainment	(16,890)			19
20	Contributions	(319)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,871)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,247)			24
25	Fund Raising, Advertising and Promotional	(58,412)			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)**	$ (124,935)		$	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)	73,021		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 73,021		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (51,914)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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

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Heritage Health Chillicothe

ID# 0048868

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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		0	20	17
18				18
19			24	19
20		(319)	27	20
21				21
22		(4,871)	19	22
23				23
24		(43,247)	27	24
25		(58,412)	20	25
26				26
27		(25)	20	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**	(106,874)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Chillicothe **#** 0048868 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	5,868	0	0	0	0	0	0	0	0	5,868	1
2	Food Purchase	0	0	34	0	0	0	0	0	0	0	0	34	2
3	Housekeeping	0	0	42	0	0	0	0	0	0	0	0	42	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,523	0	0	0	0	0	0	0	0	1,523	5
6	Maintenance	0	0	17,950	0	0	0	0	0	0	0	0	17,950	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	25,417	0	0	0	0	0	0	0	0	25,417	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	(23,601)	692	0	0	0	0	0	0	0	0	(22,909)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,045	0	0	0	0	0	0	0	0	1,045	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	(23,601)	1,737	0	0	0	0	0	0	0	0	(21,864)	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	(4,871)	(289,052)	21,071	0	0	0	0	0	0	0	0	(272,852)	19
20	Fees, Subscriptions & Promotions	(58,437)	0	8,130	0	0	0	0	0	0	0	0	(50,307)	20
21	Clerical & General Office Expenses	0	0	351,166	0	0	0	0	0	0	0	0	351,166	21
22	Employee Benefits & Payroll Taxes	0	0	52,440	0	0	0	0	0	0	0	0	52,440	22
23	Inservice Training & Education	0	(420)	1,105	0	0	0	0	0	0	0	0	685	23
24	Travel and Seminar	(16,890)	0	7,318	0	0	0	0	0	0	0	0	(9,572)	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	15,188	0	0	0	0	0	0	0	0	15,188	26
27	Other (specify):*	(43,566)	0	0	0	0	0	0	0	0	0	0	(43,566)	27
28	**TOTAL General Administration**	(123,764)	(289,472)	456,418	0	0	0	0	0	0	0	0	43,182	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,764)	(313,073)	483,572	0	0	0	0	0	0	0	0	46,735	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Chillicothe # 0048868 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	206,699	0	21,570	0	0	0	0	0	0	0	228,269	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,171)	110,715	0	(68)	0	0	0	0	0	0	0	109,476	32
33	Real Estate Taxes	0	73,873	0	0	0	0	0	0	0	0	0	73,873	33
34	Rent-Facility & Grounds	0	(481,800)	0	6,287	0	0	0	0	0	0	0	(475,513)	34
35	Rent-Equipment & Vehicles	0	0	0	8,761	0	0	0	0	0	0	0	8,761	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,171)	(90,513)	0	36,550	0	0	0	0	0	0	0	(55,134)	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	(43,515)	0	0	0	0	0	0	0	0	0	(43,515)	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	(43,515)	0	0	0	0	0	0	0	0	0	(43,515)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(124,935)	(447,101)	483,572	36,550	0	0	0	0	0	0	0	(51,914)	45

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy	0.00%	$ (23,601)	$ (23,601)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(420)	(420)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(43,515)	(43,515)	3
4	V	19	Adjustment for Related Organization	289,052	Heritage Operations Group, LLC	0.00%		(289,052)	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		73,873	73,873	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		104,965	104,965	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		206,699	206,699	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			$ 770,852			$ 323,751	$ * (447,101)	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: 01/01/15 Ending: 12/31/15

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.		$	$ 5,868	15
16	V	2	Food Purchase					34	16
17	V	3	Housekeeping					42	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,523	19
20	V	6	Maintenance					17,950	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					692	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,045	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					21,071	31
32	V	20	Fees, Subscription, Promotions					8,130	32
33	V	21	Clerical & General Office Expenses					351,166	33
34	V	22	Employee Benefits & Payroll Taxes					52,440	34
35	V	23	Inservice Training & Education					1,105	35
36	V	24	Travel and Seminar					7,318	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					15,188	38
39	Total			$			$ 0	$ * 483,572	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: 01/01/15 Ending: 12/31/15

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.		$	$ 0	15
16	V	30	Depreciation					21,570	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					(68)	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,287	20
21	V	35	Rent-Equipment & Vehicles					8,761	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	$ * 36,550	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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2,835	27	$ 151,240	$ 150,308	110	$ 5,868	1
2	2	Food Purchase	Beds	2,835	27	878	0	110	34	2
3	3	Housekeeping	Beds	2,835	27	1,094	0	110	42	3
4	4	Laundry	Beds	2,835	27	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,835	27	39,264	0	110	1,523	5
6	6	Maintenance	Beds	2,835	27	462,630	80,387	110	17,950	6
7	7	Other	Beds	2,835	27	0	0	110	0	7
8	9	Medical Director	Beds	2,835	27	0	0	110	0	8
9	10	Nursing & Medical Records	Beds	2,835	27	17,825	16,766	110	692	9
10	11	Activities	Beds	2,835	27	0	0	110	0	10
11	12	Social Service	Beds	2,835	27	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,835	27	26,928	26,075	110	1,045	12
13	14	Program Transportation	Beds	2,835	27	0	0	110	0	13
14	15	Other	Beds	2,835	27	0	0	110	0	14
15	17	Administrative	Beds	2,835	27	0	0	110	0	15
16	18	Directors Fees	Beds	2,835	27	0	0	110	0	16
17	19	Professional Services	Beds	2,835	27	543,062	0	110	21,071	17
18	20	Fees, Subscription, Promotions	Beds	2,835	27	209,523	0	110	8,130	18
19	21	Clerical & General Office Expens	Beds	2,835	27	9,050,509	8,564,147	110	351,166	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,835	27	1,351,528	0	110	52,440	20
21	23	Inservice Training & Education	Beds	2,835	27	28,468	0	110	1,105	21
22	24	Travel and Seminar	Beds	2,835	27	188,595	0	110	7,318	22
23	25	Other Admin. Staff Transportatio	Beds	2,835	27	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,835	27	391,443	0	110	15,188	24
25	TOTALS					$ 12,462,987	$ 8,837,683		$ 483,572	25

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 See Pg 8
Street Address
City / State / Zip Code
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	27	Other	Beds	2,835	27	$	$	110	$	1
2	30	Depreciation	Beds	2,835	27	555,915		110	21,570	2
3	31	Amortization of Pre-Op & Org	Beds	2,835	27			110		3
4	32	Interest	Beds	2,835	27	(1,746)		110	(68)	4
5	33	Real Estate Taxes	Beds	2,835	27			110		5
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022		110	6,287	6
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798		110	8,761	7
8	36	Other	Beds	2,835	27			110		8
9	38	Medically Nec Transportation	Beds	2,835	27			110		9
10	39	Ancillary Service Centers	Beds	2,835	27			110		10
11	40	Barber and Beauty Shops	Beds	2,835	27			110		11
12	41	Coffee and Gift Shops	Beds	2,835	27			110		12
13	42	Other	Beds	2,835	27			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					$ 941,989	$		$ 36,550	25

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Busey Bank		x	Mortgage			$	$			$ 104,965	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							37,005	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 147,720	9
	B. Non-Facility Related*											
10	Interest Income										(1,171)	10
11												11
12	Allocated Corporate										(68)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,239)	14
15	TOTALS (line 9+line14)						$	$			$ 146,481	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: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$ 73,873	2
3. Under or (over) accrual (line 2 minus line 1).		$ 73,873	3
4. Real Estate Tax accrual used for 2015 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.		$ 73,873	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011	74,372	9
2012	73,069	10
2013	73,594	11
2014	73,873	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Chillicothe COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 48868

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0529376016		$ 72,664.64	$ 72,664.64
2.	0529376017		$ 1,208.54	$ 1,208.54
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,873.18	$ 73,873.18

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 x _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,055 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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).

Evergreen Place Chillicothe LLC - Assisted living (53 units) and Memory Care (20 units). Property is adjacent only-no sharing

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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					21,570		21,570			33
34	Book Depreciation					175,203		175,203			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: 01/01/15 Ending: 12/31/15

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	$ 196,773		$ 196,773	$	$	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: 01/01/15 Ending: 12/31/15

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	$ 196,773		$ 196,773	$	$	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	$ 196,773		$ 196,773	$	$	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: 01/01/15 Ending: 12/31/15

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	$ 196,773		$ 196,773	$	$	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	Labor - Interior design of planned facility renovation	2013	12,052						27
28	Ceiling Replacement - Removal of old ceiling & asbestos	2013	46,400						28
29	Ceiling Replacement - Labor and materials to install new	2013	18,882						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,077,909	$ 196,773		$ 196,773	$	$	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: 01/01/15 Ending: 12/31/15

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	$ 196,773		$ 196,773	$	$	1
2									2
3	Install Boiler Pump	2014	2,700						3
4	Install New Compresspr	2014	3,675						4
5	Install New Disposal	2014	2,634						5
6	Facility Renovation Project -	2014	797,218						6
7	54 Patient Rooms - New Flooring, Cabinetry, Furniture								7
8	(including beds); Painting and Wallcovering Removal;								8
9	New Flooring in all hallways and other common areas;								9
10	New Tables and Chairs in both dining areas; New Cabinets								10
11	and Flooring for both Nursing Stations; New Plumbing								11
12	Fixtures Throughout entire facility								12
13									13
14	Reverse Facility Renovation Project - Record in 2016								14
15	When Entire Project is Completed	2015	(797,218)						15
16	Replaced kitchen garbage disposal	2015	2,914						16
17	Boiler- Replaced pressure regulator and relief valve	2015	5,392						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)		$ 5,095,224	$ 196,773		$ 196,773	$	$	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: 01/01/15 Ending: 12/31/15

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	$ 789,932	$ 31,496	$ 31,496	$		$	71
72	Current Year Purchases	26,540						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 816,472	$ 31,496	$ 31,496	$		$	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		2006 Turtletop Van	2006	$ 57,088	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 57,088	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,097,784	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 228,269	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,269	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: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None
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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 13,231 Description: Televisions and office equipment
    (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: 01/01/15 Ending: 12/31/15

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		3,794		3,794
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	$	$ 3,794	$	$ 3,794
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,794			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 269,452	$		$ 269,452	1
2	Licensed Speech and Language Development Therapist		hrs			54,260			54,260	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			368,682	4,906		373,588	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				518,387		518,387	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					51,876			51,876	13
14	TOTAL			$		$ 744,270	$ 523,293		$ 1,267,563	14

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 11,954	$	1
2	Cash-Patient Deposits	23,564		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,354,459		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,970		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(399,652)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,005,295	$	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)**	$ 1,005,295	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 391,610	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,564		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,122		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	Bed Tax	29,233		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 608,384	$	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)**	$ 608,384	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 396,911	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,005,295	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 241,692	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 241,692	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	155,219	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)**	$ 155,219	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)**	$ 396,911	24 *

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 5,875,355	1
2	Discounts and Allowances for all Levels	(2,459,843)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,415,512	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,367,860	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,367,860	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	707	12
13	Barber and Beauty Care	6,685	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	948,557	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,237	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 967,186	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,171	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,171	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)**	$ 6,751,729	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	963,643	31
32	Health Care	3,562,796	32
33	General Administration	1,531,451	33
	B. Capital Expense		
34	Ownership	532,036	34
	C. Ancillary Expense		
35	Special Cost Centers	6,584	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)***	$ 6,596,510	40
41	**Income before Income Taxes (line 30 minus line 40)****	155,219	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 155,219	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: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,072	1,128	$ 34,817	$ 30.87	1
2	Assistant Director of Nursing	2,078	2,188	71,711	32.77	2
3	Registered Nurses	11,965	12,595	345,756	27.45	3
4	Licensed Practical Nurses	17,840	18,779	474,551	25.27	4
5	CNAs & Orderlies	62,077	65,344	892,182	13.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,718	3,914	83,622	21.36	8
9	Activity Director					9
10	Activity Assistants	6,738	7,093	87,772	12.37	10
11	Social Service Workers	1,840	1,937	31,612	16.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,686	20,722	242,291	11.69	15
16	Dishwashers					16
17	Maintenance Workers	2,791	2,938	61,349	20.88	17
18	Housekeepers	8,834	9,299	109,627	11.79	18
19	Laundry	3,999	4,209	45,573	10.83	19
20	Administrator	1,976	2,080	80,000	38.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,814	10,330	202,491	19.60	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)	154,428	162,556	$ 2,763,354 *	$ 17.00	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		1,535		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,505		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		2,661		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,701		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Stachowiak			$ 80,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,000

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	$ 289,075
ADP	Payroll tax processing	1,157
Consova Corp	HR consulting	598
IDPH	Plan review	302
Govig & Assoc	Recruitment	5,000
Legal adj to Zero		4,871
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 301,003

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,687
Unemployment Compensation Insurance	37,167
FICA Taxes	211,397
Employee Health Insurance	273,607
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	26,633
Central Office Allocation	52,440
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,931

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	34,351
Health Care Worker Background Check	
(Indicate # of checks performed)	2,130
Patient Background Checks	
PR	8,888
Dues & Subscriptions	10,266
License & Fees	7,216
Central Office Allocation	8,130
Less: Public Relations Expense	(8,888)
Non-allowable advertising	(4,450)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,643

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	10,947
	66
Seminar Expense	3,558
	(9,572)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,048**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None claimed**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount
1009	PETTY CASH	11,954					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	1,354,459					
1110	MEDICARE RECEIVABLES						
1125	IPA INCOME RECEIVABLE						
1130	MEDICARE COST REPORT						
1135	ACCOUNTS RECEIVABLE-IC						
1140	UNAPPLIED CASH RECEIPTS						
1145	A/R SUSPENSE-REFUNDS						
1190	ACCRUED INTEREST REC						
1200	PREPAID INSURANCE	14,970					
1220	OTHER PREPAID EXPENSES						
1300	FOOD INVENTORY						
1310	SUPPLIES INVENTORY						
1409	LAND	0					
1450	FURNITURE & EQUIPMENT	0					
1460	ACCUM DEPR-FURN & EQU	0					
1475	BUILDING & IMPROVEMEN	0					
1490	ACCUM DEPR-BUILDING	0					
1530	RESIDENT FUNDS	23,564					
1550	LOAN FEES	0					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	-399,652					
2010	ACCOUNTS PAYABLE	-391,610					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	-36,300					
2110	ACCRUED VACATION PAY	-120,555					
1,009	1,009	PETTY C	11,954				
1,100	1,100	ACCTS R	1,578,303				
1,101	1,101	ALLOW.	(223,844)				
1,110	1,110	ACCTS RECEIV-M/C					
1,125	1,125	ACCTS RECEIV-IPA					
1,135	1,135	ACCTS RECEIV-IC					
1,140	1,140	UNAPPLIED CASH RECEIPTS					
1,145	1,145	A/R SUSPENSE-REFUNDS					
1,200	1,200	PREPAID	14,970				
1,220	1,220	OTHER PREPAID EXPENSES					
1,300	1,300	DIETARY INVENTORY					
1,310	1,310	SUPPLIES INVENTORY					
1,320	1,320	LINEN INVENTORY					
1,409	1,409	LAND	0				
1,450	1,450	FURNITU	0				
1,460			0				
1,475	1,475	CODE AI	0				
1,490	1,490	ACCUM I	0				
1,530	1,530	RESIDEN	23,564				
1,550	1,550	LOAN FE	0				
1,551	1,551	LOAN FEES ADDED					
1,850	1,850	INTERCC	(399,652)				
2,010	2,010	ACCOUN	(391,610)				
2,100	2,095	BONUSES PAYABLE					
2,100	2,100	ACCRUE	(36,300)				
2,100	2,100	PR CLEARING-BENEFITS					
2,100	2,100	PR CLEARING-LABOR					
2,110	2,110	ACCRUE	(120,555)				
2,120	2,120	U.C. TAX	0				

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-7,122	-7,122
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	-29,233	
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	-23,564	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-241,692	
2970	PROFIT/LOSS FOR PERIOD	-155,219	
3007.1	PATIENT DAYS-PRIVATE	9,673	

2,125	2,125	FICA TA	(7,122)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REF	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETE	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE G	
2,300	2,300	ACCRUE	0
2,320	2,320	IPA PAYI	(29,233)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DE	
2,512	2,512	DUE TO I	(23,564)
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 DE	
2,720	2,720	RETAINE	(241,692)
		net incom	(155,219)
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	18,438					3,007
3007.3		PATIENT DAYS-MEDICARE	3,600					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 &	-5,867,169	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	-8,174	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	-948,557	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-2,367,860	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	2,459,843	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	-6,685		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	-707		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-12		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	-4,738		0	0	0	0			4,110
3600		21	MISC INCOME	-6,499		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	184,467	202,491	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	80,000	80,000	17	1	0	0			4,120
4115			VACATION & SICK - G&A	18,024		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	16,028	604,491	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLARSHIP	4,821		21	1	0	0			4,250
4135			EMPLOYEE SCHOLARSHIP	5,784		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	25,002	25,002	21	2	0	0			4,275
4260			TELEPHONE	14,195	14,195	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	7,964	7,964	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	10,947	14,571	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	66		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	3,558		24	3	19	-16,890	***		4,289
4290			HELP WANTED ADVERTISI	34,351	168,175	20	3	0	0		-60,225	4,290
4291			PROMOTIONAL ADVERTIS	45,099		20	3	25	-45,099			4,291
4292			PUBLIC RELATIONS	8,888		20	3	25	-8,888			4,292
4300			LICENSES & FEES	67,441		20	3	17	-25			4,300
4310			DUES & SUBSCRIPTIONS	10,266		20	3	17	-4,425			4,310
4320			CONTRIBUTIONS	319		27	3	20	-319			4,320
4350			PROFESSIONAL FEES	11,951	301,003	19	3	22	-4,871			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 CONSI	1,535		10	3	0	0	4,364
4363	PHARMACIST FEES	5,505		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	2,661	2,661	12	3	0	0	4,383
4370	TV RENTAL	9,506		35	3	5	0	4,390
4380	INCOME TAXES		44,443	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,130		20	3	26	0	4,401
4400	PAYROLL TAXES	240,260		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,304		22	3	0	0	4,420
4410	GROUP INSURANCE	273,607		22	3	0	0	4,430
4420	LIABILITY INSURANCE	69,116	69,116	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	55,687		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	289,052		19	3	34	0 **	4,460
4460	BAD DEBTS	43,247		27	3	24	-43,247	4,461
4470	LOST ITEMS-RESIDENTS	877		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	3,725	13,231	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	50,194	61,349	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	11,155		6	1	0	0	4,510
5130	ELECTRIC	43,397	76,532	5	3	0	0	4,600
5131	NATURAL GAS	18,645		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	14,490		5	3	0	0	5,130
5134	TRASH COLLECTION	19,351	90,637	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	8,341	67,948	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	59,607		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	71,286		6	3	0	0	5,140
5210	DIETARY WAGES	221,633	242,291	1	1	0	0	5,160
5220	DIETARY SICK & VAC	20,658		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	225,481	219,433	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,224	14,168	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,836		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,108		1	2	0	0	5,260
5295	MEAL CREDIT	-6,048		2	2	0	0	5,270
5310	LAUNDRY WAGES	40,564	45,573	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	5,009		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	8,189	13,906	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,717		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	101,501	109,627	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	8,126		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	22,163	22,179	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	16		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,902,639	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	323,980		10	1	0	0	6,020
6030	DON WAGES	34,817		10	1	0	0	6,030
6035	ADON	71,711		10	1	0	0	6,035
6040	RN SICK & VACATION	21,776		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	438,718		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	35,833		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC	852,981		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	39,201		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	26,529		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	8,847		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	47,841		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WA	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	2,749	2,749	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	80,903		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,719		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	158,857	160,022	10	2	0	0	7,281
6295	NURSING SUPPLIES	658		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	507		10	2	0	0	7,391
6490	NURSING OTHER	322	90,579	10	3	0	0	7,393
7280	DRUG PURCHASES	209,447	523,293	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	308,940		39	2			7,540
7380	LABORATORY SERVICES	51,876	744,270	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	82,464	87,772	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,308		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	5,199	5,199	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	368,682		39	3	0	0 ***	7,890
7660	PT SUPPLIES	4,906		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	30,139	31,612	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,473		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	269,452		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	54,260		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	6,584	6,584	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	37,005	37,005	32	3	14	-1,171	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-1,171		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		6,595,339	6,596,510					
			1,171					
GRAND TOTALS		-155,219					-124,935	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	9,673	9,673
IPA	18,438	18,438
medicare	3,600	3,600
		31,711

UND

RIA

BT

BT

3,007 PATIENT 9,673

3,007	PATIENT	18,438
3,007	PATIENT	3,600
		0
3,010	BASIC CI	(5,867,169)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSINC	(8,174)
3,081	NURSINC	0
3,082	NURSINC	0
3,083	NURSINC	0
3,100	DRUGS-N	(948,557)
		0
3,110	PHYSICA	(2,367,860)
		0
3,112	PHYSICA	0
3,113	PHYSICA	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/OTH	0
3,411	MEDICA	0
3,420	MEDICA	2,409,178

3,520	RENT INCOME	
3,530	BEAUTY	(6,685)
		0
3,570	VENDIN(	(707)
3,590	EQUIPMI	(12)
3,595	RESIDEN	(4,738)
3,600	MISC IN(	(6,499)
4,110	G&A WA	184,467
4,111	ADMINIS	80,000
4,115	G&A PT(	18,024
4,120	EMPLOY	14,501
4,130	EMPLOY	4,821
4,135	EMPLOY	5,784
4,250	OFFICE S	14,583
4,255	POSTAG	1,415
4,260	TELEPH(	14,195
4,275	TRAININ	7,964
		300
4,280	GENERA	10,947
4,281	MEAL E)	66
4,285	EDUCAT	2,309
4,289	MEETIN(	1,249
4,290	HELP W/	34,351
4,291	PROMOT	45,099
4,292	PUBLIC I	8,888
4,300	LICENSE	67,441
4,310	DUES & S	10,266
4,320	CONTRI	319
4,350	PROFESS	11,951
4,355	MEDICA	12,000
		1,535
		5,505

4,364	SOCIAL S	2,661
4,370	TV RENT	9,506
4,383	BACKGR	2,130
4,390	OTHER T	0
4,400	PAYROL	240,260
4,401	PAYROL	8,304
4,410	GROUP I	273,607
4,420	LIABILIT	69,116
4,430	WORKM.	53,569
4,435	W/C-FIRST AID CLAIMS	
4,436	DRUG TE	1,818
4,450	MANAGI	289,052
4,460	BAD DEI	43,247
4,461	BAD DEI	50,665
4,470	LOST ITI	877
4,475	UNIFORM	1,527
4,486	SERVICE	34,204
4,490	MISC EX	298
4,496	MISC. M.	9,004
4,510	REAL ES	0
4,600	LEASED	3,725
5,110	MAINTEI	50,194
5,120	MAINTEI	11,155
5,130	ELECTRI	43,397
5,131	NATURA	18,645
5,133	WATER &	14,490
5,134	TRASH C	19,351
5,140	PROP/PL.	8,341
5,160	GENERA	59,607
5,165	MAINTEI	37,082
5,210	DIETARY	221,633
5,220	DIETARY	20,658
5,248	FOOD PU	225,183

5,250	SUPPLIE	3,224
5,260	REPLACI	1,836
5,270	KITCHEN	9,108
5,295	MEAL IN	(6,048)
5,310	LAUNDR	40,564
5,340	LAUNDR	5,009
5,370	REPLACI	8,189
		0
5,390	SUPPLIE	5,717
5,410	HOUSEK	101,501
5,440	HOUSEK	8,126
5,480	SUPPLIE	22,163
5,490	SUPPLIE	16
6,020	RN WAG	323,980
6,030	DON WA	34,817
6,035	ADON W	71,711
6,040	RN PTO &	21,776
6,120	LPN WAG	438,718
6,140	LPN PTO	35,833
6,220	AIDES W	852,981
6,240	AIDES PT	39,201
6,245		26,529
		8,847
		47,841
		0
		2,749
		0
6,270	REHAB V	80,903
6,275	REHAB P	2,719
6,290	NURSING	158,857
6,295	NURSING	658
6,390	REPLACI	507
6,490	OTHER	322

7,280	DRUG PU	209,447
7,281	DRUG PU	308,940
7,380	LABORA	18,123
7,390	X-RAY S	33,753
		0
7,510	ACTIVIT	82,464
7,540	ACTIVIT	5,308
7,590	ACTIVIT	5,199
7,620	PHYSICA	368,682
7,660	P.T. SUPI	4,906
7,710	SOCIAL S	30,139
7,720	SOCIAL S	1,473
7,730	SOCIAL S	0
7,740	OCCUPA	269,452
7,770	SPEECH	54,260
7,820	BEAUTIC	6,584
		0
		0
8,120	INTERES	0
		37,005
8,130	DEPRECI	0
		0
9,510	INTERES	(1,171)
9,520	MISC NO	0
4,220		0
8,100		481,800
9,702		0
5,230		0
		(155,219)

Expenses Fixed Assets

0