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: 0048900

Facility Name: Heritage Health Litchfield

Address: 628 S Illinois St (Number) Litchfield (City) 62056 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-2153 **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 Litchfield # 0048900 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	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,971	7,842	3,301	26,114	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,971	7,842	3,301	26,114	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.14%

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 3,301

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 Litchfield # 0048900 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	189,773	12,400		202,173		202,173	5,441	207,614			1
2	Food Purchase		194,069		194,069		194,069	33	194,102			2
3	Housekeeping	98,689	28,420		127,109		127,109	41	127,150			3
4	Laundry	44,219	23,007		67,226		67,226		67,226			4
5	Heat and Other Utilities			90,757	90,757		90,757	1,464	92,221			5
6	Maintenance	65,146	39,528	49,523	154,197		154,197	17,247	171,444			6
7	Other (specify):*											7
8	**TOTAL General Services**	397,827	297,424	140,280	835,531		835,531	24,226	859,757			8
	B. Health Care and Programs											
9	Medical Director			28,000	28,000		28,000		28,000			9
10	Nursing and Medical Records	1,460,866	84,529	5,384	1,550,779		1,550,779	(7,997)	1,542,782			10
10a	Therapy		354,066	640,472	994,538	(369,894)	624,644		624,644			10a
11	Activities	37,409	1,392		38,801		38,801		38,801			11
12	Social Services	60,140		1,702	61,842		61,842		61,842			12
13	CNA Training							1,004	1,004			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,558,415	439,987	675,558	2,673,960	(369,894)	2,304,066	(6,993)	2,297,073			16
	C. General Administration											
17	Administrative	101,080			101,080		101,080		101,080			17
18	Directors Fees											18
19	Professional Services			242,008	242,008		242,008	(219,972)	22,036			19
20	Dues, Fees, Subscriptions & Promotions			91,521	91,521	(55,845)	35,676	(6,802)	28,874			20
21	Clerical & General Office Expenses	83,671	23,715	9,754	117,140		117,140	337,409	454,549			21
22	Employee Benefits & Payroll Taxes			485,288	485,288		485,288	50,386	535,674			22
23	Inservice Training & Education			6,771	6,771		6,771	921	7,692			23
24	Travel and Seminar			3,897	3,897		3,897	1,102	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,543	47,543		47,543	14,593	62,136			26
27	Other (specify):* **Lost resident items**			14,765	14,765		14,765	(14,750)	15			27
28	**TOTAL General Administration**	184,751	23,715	901,547	1,110,013	(55,845)	1,054,168	162,887	1,217,055			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,140,993	761,126	1,717,385	4,619,504	(425,739)	4,193,765	180,120	4,373,885			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 Litchfield #0048900 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							232,966	232,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,330	34,330		34,330	101,308	135,638			32
33	Real Estate Taxes							74,018	74,018			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,931)	5,829			34
35	Rent-Equipment & Vehicles			11,748	11,748		11,748	8,124	19,872			35
36	Other (specify):*											36
37	**TOTAL Ownership**			492,838	492,838		492,838	(24,515)	468,323			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					369,894	369,894	(5,728)	364,166			39
40	Barber and Beauty Shops		388	12,105	12,493		12,493		12,493			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,845	55,845		55,845			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		388	12,105	12,493	425,739	438,232	(5,728)	432,504			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,140,993	761,514	2,222,328	5,124,835		5,124,835	149,877	5,274,712			45

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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	(739)			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				17
18	Fines and Penalties				18
19	Entertainment	(5,929)			19
20	Contributions	(350)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,959)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,400)			24
25	Fund Raising, Advertising and Promotional	(14,613)			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)**	$ (37,990)		$	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)	187,867		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 187,867		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 149,877		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 **Page 5A**

Heritage Health Litchfield

ID# **0048900**

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		(350)	27	20
21				21
22		(1,959)	19	22
23				23
24		(14,400)	27	24
25		(14,613)	20	25
26				26
27		0	22	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**	(31,322)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Litchfield **#** 0048900 **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	5,441	0	0	0	0	0	0	0	0	5,441	1
2	Food Purchase	0	0	33	0	0	0	0	0	0	0	0	33	2
3	Housekeeping	0	0	41	0	0	0	0	0	0	0	0	41	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,464	0	0	0	0	0	0	0	0	1,464	5
6	Maintenance	0	0	17,247	0	0	0	0	0	0	0	0	17,247	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	24,226	0	0	0	0	0	0	0	0	24,226	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	(8,662)	665	0	0	0	0	0	0	0	0	(7,997)	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	1,004	0	0	0	0	0	0	0	0	1,004	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	(8,662)	1,669	0	0	0	0	0	0	0	0	(6,993)	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	(1,959)	(238,259)	20,246	0	0	0	0	0	0	0	0	(219,972)	19
20	Fees, Subscriptions & Promotions	(14,613)	0	7,811	0	0	0	0	0	0	0	0	(6,802)	20
21	Clerical & General Office Expenses	0	0	337,409	0	0	0	0	0	0	0	0	337,409	21
22	Employee Benefits & Payroll Taxes	0	0	50,386	0	0	0	0	0	0	0	0	50,386	22
23	Inservice Training & Education	0	(140)	1,061	0	0	0	0	0	0	0	0	921	23
24	Travel and Seminar	(5,929)	0	7,031	0	0	0	0	0	0	0	0	1,102	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	14,593	0	0	0	0	0	0	0	0	14,593	26
27	Other (specify):*	(14,750)	0	0	0	0	0	0	0	0	0	0	(14,750)	27
28	**TOTAL General Administration**	(37,251)	(238,399)	438,537	0	0	0	0	0	0	0	0	162,887	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,251)	(247,061)	464,432	0	0	0	0	0	0	0	0	180,120	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Litchfield # 0048900 **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	212,965	0	20,001	0	0	0	0	0	0	0	232,966	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(739)	102,110	0	(63)	0	0	0	0	0	0	0	101,308	32
33	Real Estate Taxes	0	74,018	0	0	0	0	0	0	0	0	0	74,018	33
34	Rent-Facility & Grounds	0	(446,760)	0	5,829	0	0	0	0	0	0	0	(440,931)	34
35	Rent-Equipment & Vehicles	0	0	0	8,124	0	0	0	0	0	0	0	8,124	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(739)	(57,667)	0	33,891	0	0	0	0	0	0	0	(24,515)	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	(5,728)	0	0	0	0	0	0	0	0	0	(5,728)	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	(5,728)	0	0	0	0	0	0	0	0	0	(5,728)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(37,990)	(310,456)	464,432	33,891	0	0	0	0	0	0	0	149,877	45

Facility Name & ID Number Heritage Health Litchfield # 0048900 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%	$ (8,662)	$ (8,662)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(140)	(140)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(5,728)	(5,728)	3
4	V	19	Adjustment for Related Organization	238,259	Heritage Operations Group, LLC	0.00%		(238,259)	4
5	V								5
6	V	34	Adjustment for Related Organization	446,760	Heritage Manor Real Estate, LLC	0.00%		(446,760)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		74,018	74,018	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		96,207	96,207	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		212,965	212,965	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,903	5,903	10
11	V								11
12	V								12
13	V								13
14	Total			$ 685,019			$ 374,563	$ * (310,456)	14

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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.		$	$ 5,441	15
16	V	2	Food Purchase					33	16
17	V	3	Housekeeping					41	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,464	19
20	V	6	Maintenance					17,247	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					665	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,004	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					20,246	31
32	V	20	Fees, Subscription, Promotions					7,811	32
33	V	21	Clerical & General Office Expenses					337,409	33
34	V	22	Employee Benefits & Payroll Taxes					50,386	34
35	V	23	Inservice Training & Education					1,061	35
36	V	24	Travel and Seminar					7,031	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					14,593	38
39	Total			$			$ 0	$ * 464,432	39

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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					20,001	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					(63)	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,829	20
21	V	35	Rent-Equipment & Vehicles					8,124	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	$ * 33,891	39

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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 Litchfield # 0048900 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	102	$ 5,441	1
2	2	Food Purchase	Beds	2,736	27	878	0	102	33	2
3	3	Housekeeping	Beds	2,736	27	1,094	0	102	41	3
4	4	Laundry	Beds	2,736	27	0	0	102	0	4
5	5	Heat & Other Utilities	Beds	2,736	27	39,264	0	102	1,464	5
6	6	Maintenance	Beds	2,736	27	462,630	80,387	102	17,247	6
7	7	Other	Beds	2,736	27	0	0	102	0	7
8	9	Medical Director	Beds	2,736	27	0	0	102	0	8
9	10	Nursing & Medical Records	Beds	2,736	27	17,825	16,766	102	665	9
10	11	Activities	Beds	2,736	27	0	0	102	0	10
11	12	Social Service	Beds	2,736	27	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,736	27	26,928	26,075	102	1,004	12
13	14	Program Transportation	Beds	2,736	27	0	0	102	0	13
14	15	Other	Beds	2,736	27	0	0	102	0	14
15	17	Administrative	Beds	2,736	27	0	0	102	0	15
16	18	Directors Fees	Beds	2,736	27	0	0	102	0	16
17	19	Professional Services	Beds	2,736	27	543,062	0	102	20,246	17
18	20	Fees, Subscription, Promotions	Beds	2,736	27	209,523	0	102	7,811	18
19	21	Clerical & General Office Expens	Beds	2,736	27	9,050,509	8,564,147	102	337,409	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,736	27	1,351,528	0	102	50,386	20
21	23	Inservice Training & Education	Beds	2,736	27	28,468	0	102	1,061	21
22	24	Travel and Seminar	Beds	2,736	27	188,595	0	102	7,031	22
23	25	Other Admin. Staff Transportatio	Beds	2,736	27	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,736	27	391,443	0	102	14,593	24
25	TOTALS					$ 12,462,987	$ 8,837,683		$ 464,432	25

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$	$	102	$	1
2	30	Depreciation	Beds	2,835	27	555,915		102	20,001	2
3	31	Amortization of Pre-Op & Org	Beds	2,835	27			102		3
4	32	Interest	Beds	2,835	27	(1,746)		102	(63)	4
5	33	Real Estate Taxes	Beds	2,835	27			102		5
6	34	Rent-Facility & Grounds	Beds	2,835	27	162,022		102	5,829	6
7	35	Rent-Equipment & Vehicles	Beds	2,835	27	225,798		102	8,124	7
8	36	Other	Beds	2,835	27			102		8
9	38	Medically Nec Transportation	Beds	2,835	27			102		9
10	39	Ancillary Service Centers	Beds	2,835	27			102		10
11	40	Barber and Beauty Shops	Beds	2,835	27			102		11
12	41	Coffee and Gift Shops	Beds	2,835	27			102		12
13	42	Other	Beds	2,835	27			102		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 941,989	$		$ 33,891	25

Facility Name & ID Number Heritage Health Litchfield # 0048900 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			$	$			$ 96,207	1
2	Busey Bank		x	Loan Fee Amortization							5,903	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							34,330	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 136,440	9
	B. Non-Facility Related*											
10	Interest Income										(739)	10
11												11
12	Allocated Corporate										(63)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (802)	14
15	TOTALS (line 9+line14)						$	$			$ 135,638	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 Litchfield # 0048900 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.)		$ 74,018	2
3. Under or (over) accrual (line 2 minus line 1).		$ 74,018	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.		$ 74,018	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011	73,980	9
2012	71,673	10
2013	72,011	11
2014	74,018	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 Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 48900

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.	1504279009		$ 70,765.10	$ 70,765.10
2.	1504278012		$ 232.48	$ 232.48
3.	1504279015		$ 3,020.10	$ 3,020.10
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,017.68	$ 74,017.68

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 Litchfield # 0048900 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,500 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 6,816	1
2					2
3	TOTALS			$ 6,816	3

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	102				$ 3,364,350	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Symmons Mixing Valve			1997	2,000						9
10	Boiler			1997	5,612						10
11	Dinning Room Roof Repair			1997	2,755						11
12	Roof Repair			1997	3,280						12
13											13
14	Laundry Room Central Air			1996	3,019						14
15	Heritage Manor Sign			1996	2,173						15
16											16
17	Roof			1998	60,674						17
18	Booster Heater			1998	1,717						18
19	Heat/Cool Units			1998	3,433						19
20	Garbage Disposal			1998	730						20
21											21
22											22
23											23
24											24
25											25
26				1999	920						26
27	Recirculating Pump			1999	2,046						27
28	Plumbing repairs/Replacement			1999	10,045						28
29	Carpet			1999	2,335						29
30											30
31											31
32											32
33	C/O Allocation					20,001		20,001			33
34	Book Depreciation					165,391		165,391			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 Litchfield # 0048900 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	Rooftop A/C Unit	2000	$ 3,348	$		$	$	$	37
38	Blacktop Walkway	2000	2,250						38
39	Gazebo	2000	7,675						39
40									40
41	A/C Unit	2001	3,879						41
42	Gazebo	2001	981						42
43									43
44	A/C Unit	2002	1,453						44
45	A/C Unit	2002	3,120						45
46	Disposal	2002	794						46
47	Boiler	2002	1,453						47
48									48
49	A/C Unit	2003	3,458						49
50	A/C Unit	2003	833						50
51	A/C Unit	2003	2,440						51
52	A/C Unit	2003	4,542						52
53	Food Processor	2003	1,227						53
54	Ansul System	2003	1,271						54
55									55
56	Heat/Cool Units	2004	7,437						56
57	Resurface Parking Lot	2004	30,570						57
58	Roof Repair	2004	6,110						58
59	Rooftop A/C Unit	2004	3,479						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,551,409	$ 185,392		$ 185,392	$	$	70

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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		$ 3,551,409	$ 185,392		$ 185,392	$	$	1
2	Disposal	2005	842						2
3	Electrical Service	2005	8,421						3
4	A/C Units	2005	5,786						4
5	Boiler	2005	3,863						5
6	Exterior Lights	2005	1,095						6
7	Interior Remodel-- paint, wallcoverings	2005	49,155						7
8	Roof	2005	70,055						8
9	Exterior Door	2005	1,158						9
10	adjustments	2005	(4,948)						10
11	Storage Tank Replacement	2006	2,474						11
12	A/C Units	2006	13,308						12
13	Sidewalk	2006	4,566						13
14	A/C Units	2006	1,250						14
15	Exterior Door	2006	30						15
16	Roof	2006	98,093						16
17	adjustments	2006	(13,947)						17
18	HVAC	2007	6,631						18
19	Boiler	2007	1,363						19
20	Fire Panel	2007	2,007						20
21	Corridor Rehab --Paint	2007	32,114						21
22	Rheem Storage Tank	2007	3,422						22
23	Front Entry Doors	2007	4,450						23
24	Fire System	2007	6,769						24
25	Nurse Call	2007	2,565						25
26	Asbestos	2007	253						26
27	adjustments	2007	(6,680)						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,845,504	$ 185,392		$ 185,392	$	$	34

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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		$ 3,845,504	$ 185,392		$ 185,392	$	$	1
2	Corridor Rehab-- Paint	2008	11,629						2
3	Electrical Panel	2008							3
4	A/C -- Kitchen & Conf Room	2008	6,660						4
5	HVAC Boiler	2008	11,252						5
6	Exterior Rehab	2008	3,155						6
7	Nurse Call	2008	2,688						7
8	Landscaping	2008							8
9	Siding Laundry	2008	25,650						9
10	Sprinkler	2008	25,062						10
11									11
12	Resident Rm Remodel:paint, flooring & labor	2009	230,727						12
13	Backflow Preventor	2009	5,980						13
14	Windows	2009	38,840						14
15	Sprinkler system	2009	9,386						15
16	Nurse Call	2009	239,661						16
17									17
18	Resident Rm Remodel:paint, flooring & labor	2010	14,010						18
19	Generator	2010	17,868						19
20	Water Softener	2010	4,500						20
21									21
22	Air Conditioner	2011	4,680						22
23	Asphalt	2011	3,276						23
24	Water Heater	2011	13,603						24
25	Sign	2011	4,025						25
26	Exterior Windows	2011	40,675						26
27									27
28	Lighting Upgrade	2012	4,555						28
29	Computer Data Interface	2012	4,818						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,568,204	$ 185,392		$ 185,392	$	$	34

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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		$ 4,568,204	$ 185,392		$ 185,392	$	$	1
2									2
3	Drain Line Replacement	2013	5,725						3
4	PTAC's	2013	7,655						4
5									5
6	Replace 7 PTAC Units	2014	5,530						6
7	Replace Drainage System	2014	4,544						7
8	(2) Boiler Replacements	2014	27,219						8
9									9
10	Replace (5) PTAC units	2015	2,885						10
11	Exterior brick repair - cut outs and replacments	2015	11,760						11
12	Furnish and install a roof fitted exhaust fan	2015	5,832						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,639,354	$ 185,392		$ 185,392	$	$	34

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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	$	$ 35,897	$ 35,897	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$ 35,897	$ 35,897	$		$	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		2009 Turtletop bus	2008	$ 60,815	$ 7,240	$ 7,240	$		$	76
77		2008 Grand Caravan	2011	31,061	4,437	4,437				77
78										78
79										79
80	TOTALS			$ 91,876	$ 11,677	$ 11,677	$		$	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)	$ 4,738,046	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 232,966	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 232,966	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 Litchfield # 0048900 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: $ 11,748 Description: Televisions and office machines
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$		$ 307,323	$		$ 307,323	1
2	Licensed Speech and Language Development Therapist		hrs			41,993			41,993	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			273,918	1,410		275,328	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				352,656		352,656	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,238			17,238	13
14	TOTAL			$		$ 640,472	$ 354,066		$ 994,538	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 Litchfield # 0048900 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	$ 1,621	$	1
2	Cash-Patient Deposits	5,040		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,172,705		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,534		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(59,833)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,164,067	$	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)**	$ 1,164,067	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 284,292	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,040		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	233,590		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,013)		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	23,212		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 545,121	$	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)**	$ 545,121	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 618,946	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,164,067	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Litchfield # 0048900 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**	$ 215,646	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 215,646	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	403,300	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)**	$ 403,300	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)**	$ 618,946	24 *

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$ 4,896,157	1
2	Discounts and Allowances for all Levels	(2,192,214)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,703,943	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,124,252	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,124,252	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,082	12
13	Barber and Beauty Care	11,842	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	686,277	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 699,201	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	739	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 739	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)**	$ 5,528,135	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	835,531	31
32	Health Care	2,673,960	32
33	General Administration	1,110,013	33
	B. Capital Expense		
34	Ownership	492,838	34
	C. Ancillary Expense		
35	Special Cost Centers	12,493	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)***	$ 5,124,835	40
41	**Income before Income Taxes (line 30 minus line 40)****	403,300	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 403,300	43

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

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

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

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

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 01/01/15 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	1,930	2,032	$ 65,290	$ 32.13	1
2	Assistant Director of Nursing	1,451	1,527	39,116	25.62	2
3	Registered Nurses	5,026	5,291	151,859	28.70	3
4	Licensed Practical Nurses	15,329	16,136	365,267	22.64	4
5	CNAs & Orderlies	56,174	59,130	807,516	13.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,223	1,287	31,818	24.72	8
9	Activity Director					9
10	Activity Assistants	2,843	2,993	37,409	12.50	10
11	Social Service Workers	2,910	3,063	60,140	19.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,376	15,133	189,773	12.54	15
16	Dishwashers					16
17	Maintenance Workers	3,758	3,956	65,146	16.47	17
18	Housekeepers	8,513	8,961	98,689	11.01	18
19	Laundry	4,394	4,625	44,219	9.56	19
20	Administrator	1,976	2,080	101,080	48.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,501	3,685	83,671	22.71	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)	123,404	129,899	$ 2,140,993 *	$ 16.48	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		28,000		36
37	Medical Records Consultant		308		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,763		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,702		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,773		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 Litchfield # 0048900 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marge Oblinger			$ 101,080
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,080

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	$ 238,285
ADP	Payroll tax processing	1,047
Consova Corp	HR consulting	717
Legal adj to Zero		1,959
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 242,008

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,509
Unemployment Compensation Insurance	28,772
FICA Taxes	163,786
Employee Health Insurance	243,748
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	7,473
Central Office Allocation	50,386
TOTAL (agree to Schedule V, line 22, col.8)	$ 535,674

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	10,325
Health Care Worker Background Check	
(Indicate # of checks performed)	1,346
Patient Background Checks	
PR	3,738
Dues & Subscriptions	8,578
License & Fees	5,336
Central Office Allocation	7,811
Less: Public Relations Expense	(3,738)
Non-allowable advertising	(4,522)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,874

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,368
	309
Seminar Expense	2,220
	1,102
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Litchfield # 0048900 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 Litchfield # 0048900 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. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,003**

(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	1,621						1,009	1,009	PETTY C	1,621
1010	CASH IN BANK							1,100	1,100	ACCTS R	1,231,351
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW.	(58,646)
1100	ACCOUNTS RECEIVABLE	1,172,705						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	44,534
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	44,534						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	5,040
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FE	0
1530	RESIDENT FUNDS	5,040						1,551	1,551	LOAN FEES ADDED	
1550	LOAN FEES	0						1,850	1,850	INTERCC	(59,833)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	(284,292)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-59,833						2,100	2,100	ACCRUE	(111,544)
2010	ACCOUNTS PAYABLE	-284,292						2,100	2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-111,544						2,110	2,110	ACCRUE	(122,046)
2110	ACCRUED VACATION PAY	-122,046						2,120	2,120	U.C. TAX	0

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	1,013	1,013
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	-23,212	
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	-5,040	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	-215,646	
2970	PROFIT/LOSS FOR PERIOD	-403,300	
3007.1	PATIENT DAYS-PRIVATE	7,842	

2,125	2,125	FICA TA	1,013
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 PAY	(23,212)
2,350	2,350	REAL ESTATE TAXES PAYABI	
2,385			0
2,400	2,400	CURRENT PORTION OF LT DE	
2,512	2,512	DUE TO	(5,040)
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	(215,646)
		net incom	(403,300)
		balance	0
			3,007

3007.2		PATIENT DAYS-IPA	14,971					3,007
3007.3		PATIENT DAYS-MEDICARE	3,301					3,007
3007.4		PATIENT DAYS-CONVERSION						3,007
3007.5		PATIENT DAYS-LICENSED						3,007
3007.6		PATIENT DAYS-TOTAL						3,007
3010	1	BASIC CHARGE-PRIVATE &	-4,882,510	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	-7,485	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	-686,277	0	0	0	0	3,101
3101	17	DRUGS-OTHER						3,110
3110	6	PT-PRIVATE	-2,124,252	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	2,192,214	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	-11,842		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	-887		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	-195		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-6,162		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	0		0	0	0	0			4,110
3600		21	MISC INCOME	0		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	75,891	83,671	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	101,080	101,080	17	1	0	0			4,120
4115			VACATION & SICK - G&A	7,780		21	1	0	0			4,121
4120	4475		EMPLOYEE BENEFITS	7,473	485,288	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLARSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLARSHIP	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	23,715	23,715	21	2	0	0			4,275
4260			TELEPHONE	9,754	9,754	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	6,771	6,771	23	3	16	0	**		4,280
4280			GENERAL TRAVEL	1,368	3,897	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	309		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	2,220		24	3	19	-5,929	***		4,289
4290			HELP WANTED ADVERTISI	10,325	91,521	20	3	0	0	-55,845		4,290
4291			PROMOTIONAL ADVERTIS	6,353		20	3	25	-6,353			4,291
4292			PUBLIC RELATIONS	3,738		20	3	25	-3,738			4,292
4300			LICENSES & FEES	61,181		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	8,578		20	3	17	-4,522			4,310
4320			CONTRIBUTIONS	350		27	3	20	-350			4,320
4350			PROFESSIONAL FEES	3,749	242,008	19	3	22	-1,959			4,350
4355			MEDICAL DIRECTOR	28,000	28,000	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	308		10	3	0	0	4,364
4363	PHARMACIST FEES	4,763		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	1,702	1,702	12	3	0	0	4,383
4370	TV RENTAL	6,861		35	3	5	0	4,390
4380	INCOME TAXES		14,765	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,346		20	3	26	0	4,401
4400	PAYROLL TAXES	182,066		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	10,492		22	3	0	0	4,420
4410	GROUP INSURANCE	243,748		22	3	0	0	4,430
4420	LIABILITY INSURANCE	47,543	47,543	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	41,509		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	238,259		19	3	34	0 **	4,460
4460	BAD DEBTS	14,400		27	3	24	-14,400	4,461
4470	LOST ITEMS-RESIDENTS	15		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	4,887	11,748	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	60,244	65,146	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	4,902		6	1	0	0	4,510
5130	ELECTRIC	41,164	90,757	5	3	0	0	4,600
5131	NATURAL GAS	30,435		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	19,158		5	3	0	0	5,130
5134	TRASH COLLECTION	5,132	49,523	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	11,153	39,528	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	28,375		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	44,391		6	3	0	0	5,140
5210	DIETARY WAGES	175,377	189,773	1	1	0	0	5,160
5220	DIETARY SICK & VAC	14,396		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	196,072	194,069	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,628	12,400	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,465		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	6,307		1	2	0	0	5,260
5295	MEAL CREDIT	-2,003		2	2	0	0	5,270
5310	LAUNDRY WAGES	40,958	44,219	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,261		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	4,683	23,007	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	18,324		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	90,737	98,689	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	7,952		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	28,208	28,420	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	212		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,460,866	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	142,931		10	1	0	0	6,020
6030	DON WAGES	65,290		10	1	0	0	6,030
6035	ADON	39,116		10	1	0	0	6,035
6040	RN SICK & VACATION	8,928		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	344,077		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	21,190		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC/	752,080		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	55,436		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	31,906		10	1	0	0	6,390
6275	REHAB SICK & VAC	-88		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	22,717	84,529	10	2	0	0	7,281
6295	NURSING SUPPLIES	56,952		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	4,860		10	2	0	0	7,391
6490	NURSING OTHER	313	5,384	10	3	0	0	7,393
7280	DRUG PURCHASES	131,987	354,066	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	220,669		39	2			7,540
7380	LABORATORY SERVICES	17,238	640,472	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	32,662	37,409	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,747		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	1,392	1,392	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	273,918		39	3	0	0 ***	7,890
7660	PT SUPPLIES	1,410		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	55,826	60,140	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	4,314		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	307,323		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	41,993		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	12,105	12,105	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	388	388	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	446,760	446,760	34	3	0	0	

8120	INTEREST EXPENSE	34,330	34,330	32	3	14	-739	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-739		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		5,124,096	5,124,835					
			739					
GRAND TOTALS		-403,300					-37,990	
		(NET INCOME)						
		0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	7,842	7,842
IPA	14,971	14,971
medicare	3,301	3,301
		26,114

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BT

3,007 PATIENT 7,842

3,007	PATIENT	14,971
3,007	PATIENT	3,301
		0
3,010	BASIC CI	(4,882,510)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSINC	(7,485)
3,081	NURSINC	0
3,082	NURSINC	0
3,083	NURSINC	0
3,100	DRUGS-N	(686,277)
		0
3,110	PHYSICA	(2,124,252)
		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	2,113,521

3,520	RENT INCOME	
3,530	BEAUTY	(11,842)
		(887)
3,570	VENDIN(	(195)
3,590	EQUIPMI	(6,162)
3,595	RESIDEN	0
3,600	MISC IN(	0
4,110	G&A WA	75,891
4,111	ADMINIS	101,080
4,115	G&A PT(	7,780
4,120	EMPLOY	7,617
4,130	EMPLOYEE SCHOLARSHIPS	
4,135	EMPLOYEE SCHOLARSHIPS-COSTS	
4,250	OFFICE S	8,423
4,255	POSTAG	2,761
4,260	TELEPH(	9,754
4,275	TRAININ	6,771
		0
4,280	GENERA	1,368
4,281	MEAL E)	309
4,285	EDUCAT	2,220
4,289	MEETINGS EXPENSE	
4,290	HELP W/	10,325
4,291	PROMOT	6,353
4,292	PUBLIC I	3,738
4,300	LICENSE	61,181
4,310	DUES & S	8,578
4,320	CONTRI	350
4,350	PROFESS	3,749
4,355	MEDICA	28,000
		308
		4,763

4,364	SOCIAL S	1,702
4,370	TV RENT	6,861
4,383	BACKGR	1,346
4,390	OTHER TAXES	
4,400	PAYROL	182,066
4,401	PAYROL	10,492
4,410	GROUP I	243,748
4,420	LIABILIT	47,543
4,430	WORKM.	40,829
4,435	W/C-FIRST AID CLAIMS	
4,436	DRUG TE	680
4,450	MANAGI	238,259
4,460	BAD DEI	14,400
4,461	BAD DEI	78,693
4,470	LOST ITI	15
4,475	UNIFORM	(144)
4,486	SERVICE	27,579
4,490	MISC EX	125
4,496	MISC. M.	12,531
4,510	REAL ES	0
4,600	LEASED	4,887
5,110	MAINTEI	60,244
5,120	MAINTEI	4,902
5,130	ELECTRI	41,164
5,131	NATURA	30,435
5,133	WATER &	19,158
5,134	TRASH C	5,132
5,140	PROP/PL.	11,153
5,160	GENERA	28,375
5,165	MAINTEI	16,812
5,210	DIETARY	175,377
5,220	DIETARY	14,396
5,248	FOOD PU	195,947

5,250	SUPPLIE	2,628
5,260	REPLACI	3,465
5,270	KITCHEN	6,307
5,295	MEAL IN	(2,003)
5,310	LAUNDR	40,958
5,340	LAUNDR	3,261
5,370	REPLACI	4,683
		18,324
5,390	SUPPLIES	
5,410	HOUSEK	90,737
5,440	HOUSEK	7,952
5,480	SUPPLIE	28,208
5,490	SUPPLIE	212
6,020	RN WAG	142,931
6,030	DON WA	65,290
6,035	ADON W	39,116
6,040	RN PTO &	8,928
6,120	LPN WAG	344,077
6,140	LPN PTO	21,190
6,220	AIDES W	752,080
6,240	AIDES PT	55,436
6,245		
		0
		0
		0
6,270	REHAB V	31,906
6,275	REHAB P	(88)
6,290	NURSING	22,717
6,295	NURSING	56,952
6,390	REPLACI	4,860
6,490	OTHER	313

7,280	DRUG PU	131,987
7,281	DRUG PU	220,669
7,380	LABORA	9,263
7,390	X-RAY S	7,975
		0
7,510	ACTIVIT	32,662
7,540	ACTIVIT	4,747
7,590	ACTIVIT	1,392
7,620	PHYSICA	273,918
7,660	P.T. SUPI	1,410
7,710	SOCIAL S	55,826
7,720	SOCIAL S	4,314
7,730	SOCIAL SERVICE-EXPENSES	
7,740	OCCUPA	307,323
7,770	SPEECH	41,993
7,820	BEAUTIC	12,105
		388
		0
8,120	INTERES	0
		34,330
8,130	DEPRECI	0
		0
9,510	INTERES	(739)
9,520	MISC NO	0
4,220		0
8,100		446,760
9,702		0
5,230		0
		(403,300)

Expenses Fixed Assets

0