FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 01/01/16 to 12/31/16 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: 01/01/16 Ending: 12/31/16

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 7/26/16

	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)	106	39,264	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	106	39,264	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	16,997	9,259	3,054	29,310	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,997	9,259	3,054	29,310	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.65%

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 3,054

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: 01/01/16 Ending: 12/31/16

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	236,926	12,935		249,861		249,861	5,545	255,406			1
2	Food Purchase		220,209		220,209		220,209		220,209			2
3	Housekeeping	91,351	25,964		117,315		117,315	40	117,355			3
4	Laundry	41,622	12,772		54,394		54,394		54,394			4
5	Heat and Other Utilities			74,281	74,281		74,281	1,723	76,004			5
6	Maintenance	62,023	48,471	83,013	193,507		193,507	23,200	216,707			6
7	Other (specify):*											7
8	TOTAL General Services	431,922	320,351	157,294	909,567		909,567	30,508	940,075			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,834,450	157,361	89,792	2,081,603		2,081,603	(22,406)	2,059,197			10
10a	Therapy		720,510	17,572	738,082	(735,016)	3,066		3,066			10a
11	Activities	93,079	4,931		98,010		98,010		98,010			11
12	Social Services	31,432		1,028	32,460		32,460		32,460			12
13	CNA Training	2,238	1,472		3,710		3,710	1,366	5,076			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,961,199	884,274	120,392	2,965,865	(735,016)	2,230,849	(21,040)	2,209,809			16
	C. General Administration											
17	Administrative	85,000			85,000		85,000		85,000			17
18	Directors Fees											18
19	Professional Services			315,217	315,217		315,217	(291,931)	23,286			19
20	Dues, Fees, Subscriptions & Promotions			340,532	340,532	(220,097)	120,435	(69,502)	50,933			20
21	Clerical & General Office Expenses	209,835	16,359	14,933	241,127		241,127	323,798	564,925			21
22	Employee Benefits & Payroll Taxes			474,954	474,954		474,954	43,699	518,653			22
23	Inservice Training & Education			7,260	7,260		7,260	1,339	8,599			23
24	Travel and Seminar			13,699	13,699		13,699	(8,700)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,275	55,275		55,275	18,331	73,606			26
27	Other (specify):*			160,382	160,382		160,382	(160,382)				27
28	TOTAL General Administration	294,835	16,359	1,382,252	1,693,446	(220,097)	1,473,349	(143,348)	1,330,001			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,687,956	1,220,984	1,659,938	5,568,878	(955,113)	4,613,765	(133,880)	4,479,885			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 Chillicothe #0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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							385,031	385,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,945	49,945		49,945	177,963	227,908			32
33	Real Estate Taxes							82,848	82,848			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(475,252)	6,548			34
35	Rent-Equipment & Vehicles			15,269	15,269		15,269	9,869	25,138			35
36	Other (specify):*											36
37	**TOTAL Ownership**			547,014	547,014		547,014	180,459	727,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			755,353	755,353	735,016	1,490,369	(235,252)	1,255,117			39
40	Barber and Beauty Shops			7,813	7,813		7,813		7,813			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					220,097	220,097		220,097			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			763,166	763,166	955,113	1,718,279	(235,252)	1,483,027			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,687,956	1,220,984	2,970,118	6,879,058		6,879,058	(188,673)	6,690,385			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: 01/01/16 Ending: 12/31/16

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	(2,804)			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	(15,617)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,655)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,382)			24
25	Fund Raising, Advertising and Promotional	(80,085)			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)**	$ (282,543)		$	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)	93,870		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 93,870		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (188,673)		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

Heritage Health Chillicothe

ID# 0048868

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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		0	27	20
21				21
22		(23,655)	19	22
23				23
24		(160,382)	27	24
25		(80,085)	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	(264,122)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	5,545	0	0	0	0	0	0	0	0	5,545	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	40	0	0	0	0	0	0	0	0	40	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,723	0	0	0	0	0	0	0	0	1,723	5
6	Maintenance	0	0	23,200	0	0	0	0	0	0	0	0	23,200	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	30,508	0	0	0	0	0	0	0	0	30,508	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	(22,746)	340	0	0	0	0	0	0	0	0	(22,406)	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	1,366	0	0	0	0	0	0	0	0	1,366	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	(22,746)	1,706	0	0	0	0	0	0	0	0	(21,040)	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	(23,655)	(289,535)	21,259	0	0	0	0	0	0	0	0	(291,931)	19
20	Fees, Subscriptions & Promotions	(80,085)	0	10,583	0	0	0	0	0	0	0	0	(69,502)	20
21	Clerical & General Office Expenses	0	0	323,798	0	0	0	0	0	0	0	0	323,798	21
22	Employee Benefits & Payroll Taxes	0	0	43,699	0	0	0	0	0	0	0	0	43,699	22
23	Inservice Training & Education	0	0	1,339	0	0	0	0	0	0	0	0	1,339	23
24	Travel and Seminar	(15,617)	0	6,917	0	0	0	0	0	0	0	0	(8,700)	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	18,331	0	0	0	0	0	0	0	0	18,331	26
27	Other (specify):*	(160,382)	0	0	0	0	0	0	0	0	0	0	(160,382)	27
28	**TOTAL General Administration**	(279,739)	(289,535)	425,926	0	0	0	0	0	0	0	0	(143,348)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(279,739)	(312,281)	458,140	0	0	0	0	0	0	0	0	(133,880)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Chillicothe **#** 0048868 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	354,882	0	30,149	0	0	0	0	0	0	0	385,031	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,804)	180,443	0	324	0	0	0	0	0	0	0	177,963	32
33	Real Estate Taxes	0	82,848	0	0	0	0	0	0	0	0	0	82,848	33
34	Rent-Facility & Grounds	0	(481,800)	0	6,548	0	0	0	0	0	0	0	(475,252)	34
35	Rent-Equipment & Vehicles	0	0	0	9,869	0	0	0	0	0	0	0	9,869	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,804)	136,373	0	46,890	0	0	0	0	0	0	0	180,459	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	(235,252)	0	0	0	0	0	0	0	0	0	(235,252)	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	(235,252)	0	0	0	0	0	0	0	0	0	(235,252)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(282,543)	(411,160)	458,140	46,890	0	0	0	0	0	0	0	(188,673)	45

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy	0.00%	$ (22,746)	$ (22,746)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(235,252)	(235,252)	3
4	V	19	Adjustment for Related Organization	289,535	Heritage Operations Group, LLC	0.00%		(289,535)	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		82,848	82,848	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		163,496	163,496	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		354,882	354,882	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		16,947	16,947	10
11	V								11
12	V								12
13	V								13
14	Total			$ 771,335			$ 360,175	$ * (411,160)	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: 01/01/16 Ending: 12/31/16

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 Operations Group LLC		$	$ 5,545	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					40	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,723	19
20	V	6	Maintenance					23,200	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					340	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,366	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					21,259	31
32	V	20	Fees, Subscription, Promotions					10,583	32
33	V	21	Clerical & General Office Expenses					323,798	33
34	V	22	Employee Benefits & Payroll Taxes					43,699	34
35	V	23	Inservice Training & Education					1,339	35
36	V	24	Travel and Seminar					6,917	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					18,331	38
39	Total			$			$ 0	$ * 458,140	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: 01/01/16 Ending: 12/31/16

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 Operations Group LLC		$	$ 0	15
16	V	30	Depreciation					30,149	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					324	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,548	20
21	V	35	Rent-Equipment & Vehicles					9,869	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	$ * 46,890	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	2,571	26	$ 134,491	$ 133,835	106	$ 5,545	1
2	2	Food Purchase	Beds	2,571	26	0	0	106	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	106	40	3
4	4	Laundry	Beds	2,571	26	0	0	106	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	106	1,723	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	106	23,200	6
7	7	Other	Beds	2,571	26	0	0	106	0	7
8	9	Medical Director	Beds	2,571	26	0	0	106	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	106	340	9
10	11	Activities	Beds	2,571	26	0	0	106	0	10
11	12	Social Service	Beds	2,571	26	0	0	106	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	106	1,366	12
13	14	Program Transportation	Beds	2,571	26	0	0	106	0	13
14	15	Other	Beds	2,571	26	0	0	106	0	14
15	17	Administrative	Beds	2,571	26	0	0	106	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	106	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	106	21,259	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	106	10,583	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	106	323,798	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	106	43,699	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	106	1,339	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	106	6,917	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	106	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	106	18,331	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 458,140	25

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	27	Other	Beds	2,571	26	$	$	106	$	1
2	30	Depreciation	Beds	2,571	26	731,247		106	30,149	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			106		3
4	32	Interest	Beds	2,571	26	7,851		106	324	4
5	33	Real Estate Taxes	Beds	2,571	26			106		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		106	6,548	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		106	9,869	7
8	36	Other	Beds	2,571	26			106		8
9	38	Medically Nec Transportation	Beds	2,571	26			106		9
10	39	Ancillary Service Centers	Beds	2,571	26			106		10
11	40	Barber and Beauty Shops	Beds	2,571	26			106		11
12	41	Coffee and Gift Shops	Beds	2,571	26			106		12
13	42	Other	Beds	2,571	26			106		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					$ 1,137,301	$		$ 46,890	25

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$			$ 163,496	1
2	Busey Bank		x	Loan Fee Amortization							16,947	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Line of credit							49,945	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 230,388	9
	B. Non-Facility Related*											
10	Interest Income										(2,804)	10
11												11
12	Allocated Corporate										324	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,480)	14
15	TOTALS (line 9+line14)						$	$			$ 227,908	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	$	82,848	2
3. Under or (over) accrual (line 2 minus line 1).	$	82,848	3
4. Real Estate Tax accrual used for 2016 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.	$	82,848	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	74,372	8
2012	73,069	9
2013	73,594	10
2014	73,873	11
2015	82,848	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Chillicothe COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0048868

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0529376016		$ 81,567.02	$ 81,567.00
2.	0529376017		$ 1,280.60	$ 1,281.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,847.62	$ 82,848.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,914 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).

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

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: 01/01/16 Ending: 12/31/16

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	106				$ 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					30,149		30,149			33
34	Book Depreciation					304,791		304,791			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: 01/01/16 Ending: 12/31/16

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	$ 334,940		$ 334,940	$	$	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: 01/01/16 Ending: 12/31/16

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	$ 334,940		$ 334,940	$	$	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	$ 334,940		$ 334,940	$	$	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: 01/01/16 Ending: 12/31/16

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	$ 334,940		$ 334,940	$	$	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	$ 334,940		$ 334,940	$	$	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: 01/01/16 Ending: 12/31/16

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	$ 334,940		$ 334,940	$	$	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									6
7	Replaced kitchen garbage disposal	2015	2,914						7
8	Boiler- Replaced pressure regulator and relief valve	2015	5,392						8
9									9
10	Install flood lights for the back parking lot	2016	2,926						10
11	Landscaping front parking lot and front entrance -	2016	10,585						11
12	removing previous materials and replacing with new								12
13	mulch, topsoil, bricks and plants								13
14									14
15	Full Facility Renovation Project -	2016	2,653,564						15
16	Each of the 54 Patient Rooms received New Flooring, Cabinetry, Furniture								16
17	(including beds), wallcover removal and fresh painting								17
18	New Flooring in all hallways and other common areas;								18
19	New Tables and Chairs in both dining areas; New Cabinets								19
20	and Flooring for both Nursing Stations; New Plumbing								20
21	fixtures throughout entire facility;								21
22	Constructed a new dining area - 852 square foot contiguous								22
23	addition to existing building;								23
24	Relocated existing therapy unit to old dining room-installed new flooring and equipment								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)		$ 7,762,299	$ 334,940		$ 334,940	$	$	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: 01/01/16 Ending: 12/31/16

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	$ 816,472	$ 50,091	$ 50,091	$		$	71
72	Current Year Purchases	227,428						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,043,900	$ 50,091	$ 50,091	$		$	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)	$ 8,992,287	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 385,031	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 385,031	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: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 15,269 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	None		$	$	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: 01/01/16 Ending: 12/31/16

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		1,472		1,472
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,238		2,238
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 3,710	$	$ 3,710
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,710			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 337,595	$		$ 337,595	1
2	Licensed Speech and Language Development Therapist		hrs			24,396			24,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			393,362	3,066		396,428	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				717,444		717,444	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,572			17,572	13
14	TOTAL			$		$ 772,925	$ 720,510		$ 1,493,435	14

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

Facility Name & ID Number Heritage Health Chillicothe **#** 0048868 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 55,313	$	1
2	Cash-Patient Deposits	25,566		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,566,617		3
4	Supply Inventory (priced at)	1,869		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,109		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(778,067)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 901,407	$	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)**	$ 901,407	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 239,081	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,566		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,218		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,145		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	27,497		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 484,507	$	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)**	$ 484,507	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 416,900	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 901,407	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 396,912	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 396,912	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	19,988	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)**	$ 19,988	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)**	$ 416,900	24 *

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 5,919,676	1
2	Discounts and Allowances for all Levels	(2,554,565)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,365,111	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,235,200	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,235,200	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	462	12
13	Barber and Beauty Care	7,729	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,284,008	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,732	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,295,931	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,804	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,804	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)**	$ 6,899,046	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	909,567	31
32	Health Care	2,965,865	32
33	General Administration	1,693,446	33
	B. Capital Expense		
34	Ownership	547,014	34
	C. Ancillary Expense		
35	Special Cost Centers	763,166	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)***	$ 6,879,058	40
41	**Income before Income Taxes (line 30 minus line 40)****	19,988	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 19,988	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: 01/01/16 Ending: 12/31/16

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	1,490	1,568	$ 67,550	$ 43.08	1
2	Assistant Director of Nursing	2,448	2,577	89,758	34.83	2
3	Registered Nurses	10,745	11,311	364,636	32.24	3
4	Licensed Practical Nurses	12,155	12,795	342,883	26.80	4
5	CNAs & Orderlies	60,120	63,284	914,693	14.45	5
6	CNA Trainees	248	261	2,238	8.57	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,127	2,239	54,930	24.53	8
9	Activity Director					9
10	Activity Assistants	6,552	6,897	93,079	13.50	10
11	Social Service Workers	1,768	1,861	31,432	16.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,236	20,248	236,926	11.70	15
16	Dishwashers					16
17	Maintenance Workers	2,856	3,006	62,023	20.63	17
18	Housekeepers	7,629	8,031	91,351	11.37	18
19	Laundry	3,747	3,944	41,622	10.55	19
20	Administrator	1,984	2,088	85,000	40.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,112	9,592	209,835	21.88	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)	142,217	149,702	$ 2,687,956 *	$ 17.96	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		1,197		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,845		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		1,028		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,070		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		69,560		51
52	Certified Nurse Assistants/Aides		16,351		52
53	TOTAL (lines 50 - 52)		$ 85,911		53

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Stachowiak			$ 85,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,000

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 services	$ 289,534
ADP	Payroll tax processing	1,331
Tango Inc	ACA compliance	697
Legal adj to Zero		23,655
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 315,217

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,682
Unemployment Compensation Insurance	30,194
FICA Taxes	205,629
Employee Health Insurance	138,940
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	32,509
Central Office Allocation	43,699
TOTAL (agree to Schedule V, line 22, col.8)	$ 518,653

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	23,393
Health Care Worker Background Check	
(Indicate # of checks performed)	2,578
PR	26,847
Dues & Subscriptions	13,432
License & Fees	5,564
Central Office Allocation	10,583
Less: Public Relations Expense	(26,847)
Non-allowable advertising	(4,617)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,933

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	11,678
	270
Seminar Expense	1,751
	(8,700)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Chillicothe # 0048868 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. $ **220,097**
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? **No** Indicate the amount. $ **0**

(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?
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	55,313							1,009	1,009	CASH	55,313
1010			CASH IN BANK								1,100	1,100	ACCTS RI	1,945,757
1040			CASH IN BANK-PAYROLL								1,101	1,101	ALLOW. I	(379,140)
1100			ACCOUNTS RECEIVABLE	1,566,617							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	30,109
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	30,109							1,310	1,310	SUPPLIES	1,869
1220			OTHER PREPAID EXPENSES								1,320	1,320	LINEN INVENTORY	
1300			FOOD INVENTORY								1,409	1,409	LAND	0
1310			SUPPLIES INVENTORY	1,869							1,450	1,450	FURNITU	0
1409			LAND	0							1,460			0
1450			FURNITURE & EQUIPMENT	0							1,475	1,475	BUILDIN	0
1460			ACCUM DEPR-FURN & EQUI	0							1,490	1,490	ACCUM I	0
1475			BUILDING & IMPROVEMENT	0							1,530	1,530	RESIDEN	25,566
1490			ACCUM DEPR-BUILDING	0							1,550	1,550	LOAN FE	0
1530			RESIDENT FUNDS	25,566							1,551	1,551	LOAN FEES ADDED	
1550			LOAN FEES	0							1,850	1,850	INTERCO	(778,067)
1560			REAL ESTATE TAX ESCROW								2,010	2,010	ACCOUN	(239,081)
1575			REIMBURSABLE PURCHASES								2,100	2,095	BONUSES PAYABLE	
1850			INTRACOMPANY	-778,067							2,100	2,100	ACCRUEI	(62,502)
2010			ACCOUNTS PAYABLE	-239,081							2,100	2,100	PR CLEARING-BENEFITS	
2095			BONUSES PAYABLE								2,100	2,100	PR CLEARING-LABOR	
2100			ACCRUED PAYROLL	-62,502							2,110	2,110	ACCRUEI	(122,716)
2110			ACCRUED VACATION PAY	-122,716							2,120	2,120	U.C. TAX	0
2120			UC TAXES PAYABLE								2,125	2,125	FICA TAX	(7,145)
2125			FICA TAX PAYABLE	-7,145	-7,145						2,130	2,130	FEDERAL W/H TAX PAYABLE	
2130			FIT PAYABLE								2,140	2,140	STATE W/H TAX PAYABLE	
2140			STATE W/H PAYABLE		0						2,152	2,152	WORKERS COMP ACCRUAL	
2145			EARNED INCOME CREDIT								2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2150			UC FED CREDIT REDUCTION								2,230	2,230	PAYROLL SAVINGS	
2230			PAYROLL SAVINGS								2,235	2,240	UNITED FUND	
2235			IRA W/HOLDINGS								2,240	2,246	GROUP INSURANCE - CAFETERIA	
2240			UNITED WAY								2,246	2,250	401K W/H	
2245			GROUP INSURANCE PAYABLE								2,250			
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260	WAGE G/	0
2260			WAGE GARNISHMENTS								2,300	2,300	ACCRUEI	0
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320	IPA PAYI	(27,497)
2300			ACCRUED INTEREST PAYAI	0							2,350	2,350	REAL ES	0
2310			SALES TAX PAYABLE								2,385			0
2320			IPA PAYMENTS PAYABLE	-27,497							2,400	2,400	CURRENT PORTION OF LT DEBT	
2350			REAL ESTATE TAX PAYABL	0							2,512	2,512	DUE TO F	(25,566)
2385			ACTIVITY FUND	0							2,600	2,600	LASALLE	0
2390			SECURITY DEPOSITS	0							2,600			
2391			VOLUNTEER FUND								2,625	2,625	LASALLE CONSTR. LOAN #2	
2393			HEART FUND/BAZAAR								2,625			
2395			DEFERRED INC EMP & MEM								2,695	2,695	CURRENT PORTION OF LT DEBT	
2400			CURRENT PORTION LT DEBT								2,720	2,720	RETAINE	(396,912)
2460			INCOME TAXES PAYABLE										net income	(19,988)
2512			DUE TO RESIDENTS	-25,566										
2600			MORTGAGE PAYABLE	0										
2650			EQUIPMENT LOAN PAYABLE										balance	0
2695			CURRENT PORTION LT DEBT											
2696			DEFERRED INCOME TAXES											
2710			COMMON STOCK											
2720			RETAINED EARNINGS	-396,912										
2970			PROFIT/LOSS FOR PERIOD	-19,988										
3007.1			PATIENT DAYS-PRIVATE	9,259							3,007	3,007	PATIENT DA	9,259
3007.2			PATIENT DAYS-IPA	16,997							3,007	3,007	PATIENT DA	16,997
3007.3			PATIENT DAYS-MEDICARE	3,054							3,007	3,007	PATIENT DA	3,054
3007.4			PATIENT DAYS-CONVERSION								3,007			0
3007.5			PATIENT DAYS-LICENSED								3,007			
3007.6			PATIENT DAYS-TOTAL								3,007			
3010		1	BASIC CHARGE-PRIVATE &	-5,909,313		0	0	0	0		3,007			
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3,010	3,010	BASIC CHAR	(5,909,313)
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		3,020	3,020	BASIC CHAR	0
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		3,030	3,030	BASIC CHAR	0
3035		4	DAY CARE/HOME CARE			0	0	0	0		3,040			160,661
3040		1	LIGHT NURSING CARE			0	0	0	0		3,050			0
3050		1	MEDIUM NURSING CARE			0	0	0	0		3,060			0
3060		1	HEAVY NURSING CARE			0	0	0	0		3,061			0
3061		1	SKILLED NURSING CARE								3,080	3,080	NURSING SU	(5,994)
3080		1	NURSING SUPPLIES-PRIVAT	-5,994		0	0	0	0		3,081	3,081	NURSING SU	0
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3,082	3,082	NURSING SU	0
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3,083	3,083	NURSING SU	0
3083		1	NURSING SUPPLIES MED PT B								3,100	3,100	DRUGS-MED	(1,284,008)
3100		17	DRUGS	-1,284,008		0	0	0	0		3,101			0
3101		17	DRUGS-OTHER								3,110	3,110	PHYSICAL TI	(2,235,200)
3110		6	PT-PRIVATE	-2,235,200		0	0	0	0		3,111			0
3111		6	PT-IPA			0	0	0	0		3,112	3,112	PHYSICAL TI	0
3112		6	PT-MEDICARE PART A			0	0	0	0		3,113	3,113	PHYSICAL TI	0
3113		6	PT-MEDICARE PART B			0	0	0	0		3,140	3,140	LABORATORY INCOME	
3130		1	PUBLIC AID ASSESSMENT II	160,661							3,150			0
3140		19	LABORATORY INCOME			0	0	0	0		3,151			
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3,152	3,152	ST/OT THER/	0
3151		6	SPEECH/OT-IPA			0	0	0	0		3,153	3,153	ST/OT THER/	0
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3153		6	SPEECH/OT MED PART B								3,410	3,410	IPA/OTHER I	0
3410		2	IPA DISCOUNTS	2,554,565		0	0	0	0		3,411	3,411	MEDICARE F	0
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3,420	3,420	MEDICARE I	2,477,567
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3,500			
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3,520	3,520	RENT INCOM	0
3520		16	RENT INCOME	0		6	0	6	0		3,530	3,530	BEAUTY SHO	(7,729)
3530		13	BEAUTY SHOP	-7,729		0	0	0	0		3,560			0
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		3,570	3,570		(462)
3570		12	VENDING INCOME/EXPENSI	-462		0	0	0	0		3,590	3,590	EQUIPMENT	(4,369)
3580		12	MANAGEMENT FEES			0	0	0	0		3,595	3,595	RESIDENT TI	(2,814)
3590		1	EQUIPMENT RENTAL	-4,369		0	0	0	0		3,600	3,600	MISC INCOM	(918)
3595		21	RESIDENT TRANSPORTATIC	-2,814		0	0	0	0		4,110	4,110	G&A WAGES	193,015
3600		21	MISC INCOME	-918		0	0	0	0		4,111	4,111	ADMINISTR/	85,000
4110			GENERAL & ADMINIST WA(	193,015	209,835	21	1	17	0		4,115	4,115	G&A PTO & I	16,820
4111			ADMINISTRATOR WAGES	85,000	85,000	17	1	0	0		4,120	4,120	EMPLOYEE I	13,011
4115			VACATION & SICK - G&A	16,820		21	1	0	0		4,121			
4120	4475		EMPLOYEE BENEFITS	11,507	474,954	22	3	0	0		4,130	4,130	EMPLOYEE S	12,132
4125			EMPLOYEE HEPETITIS VAC(	0		22	3	0	0		4,135	4,135	EMPLOYEE S	8,870
4130			EMPLOYEE SCHOLORSHIP V	12,132	160,661	21	1	0	0		4,250	4,250	OFFICE SUPI	6,767
4135			EMPLOYEE SCHOLORSHIP (	8,870		23	3	0	0		4,255	4,255	POSTAGE	1,360
4220			DIRECTORS FEES	0	0	18	3	0	0		4,260	4,260	TELEPHONE	14,933
4250	4255		OFFICE SUPPLIES	16,359	16,359	21	2	0	0		4,275	4,275	TRAINING &	7,260
4260			TELEPHONE	14,933	14,933	21	3	0	0		4,276			
4275			TRAINING & EMPLOYEE DE	7,260	7,260	23	3	16	0	**	4,280	4,280	GENERAL TI	11,678
4280			GENERAL TRAVEL	11,678	13,699	24	3	16	0		4,281	4,281	MEAL EXPEI	270
4281			MEAL EXPENSE FOR TRAVE	270		24	3	19	0		4,285	4,285	EDUCATION	1,107
4285			EDUCATION & SEMINAR	1,751		24	3	19	-15,617	***	4,289	4,289	MEETINGS E	644
4290			HELP WANTED ADVERTISIN	23,393	179,871	20	3	0	0	-59,436	4,290	4,290	HELP WANTI	23,393
4291			PROMOTIONAL ADVERTISII	48,621		20	3	25	-48,621		4,291	4,291	PROMOTION	48,621
4292			PUBLIC RELATIONS	26,847		20	3	25	-26,847		4,292	4,292	PUBLIC REL/	26,847
4300			LICENSES & FEES	65,000		20	3	17	0		4,300	4,300	LICENSE & F	65,000
4310			DUES & SUBSCRIPTIONS	13,432		20	3	17	-4,617		4,310	4,310	DUES & SUB	13,432
4320			CONTRIBUTIONS	0		27	3	20	0		4,320	4,320	CONTRIBUTI	0
4350			PROFESSIONAL FEES	25,682	315,217	19	3	22	-23,655		4,350	4,350	PROFESSION	25,682
4355			MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		4,355	4,355	MEDICAL DI	12,000
4360			UTILIZATION REVIEW	0		10	3	0	0		4,362			1,197
4361			OTHER PHYSICIAN FEES			39	3	0	0		4,363			4,845
4362			MEDICAL RECORDS CONSU	1,197		10	3	0	0		4,364	4,364	SOCIAL SER'	1,028
4363			PHARMACIST FEES	4,845		10	3	0	0		4,370	4,370	TV RENTAL	10,359
4364			SOC SERV/ACT CONSULT	1,028	1,028	12	3	0	0		4,383	4,383	BACKGROUI	2,578
4370			TV RENTAL	10,359		35	3	5	0		4,390	4,390	OTHER TAXI	0
4380			INCOME TAXES		160,382	27	3	26	0		4,400	4,400	PAYROLL T/	227,000
4383			BACKGROUND CHECKS	2,578		20	3	26	0		4,401	4,401	PAYROLL T/	8,823
4400			PAYROLL TAXES	227,000		22	3	0	0		4,410	4,410	GROUP INSU	138,940
4401			PAYROLL TAXES ADMINIST	8,823		22	3	0	0		4,420	4,420	LIABILITY IN	55,275
4410			GROUP INSURANCE	138,940		22	3	0	0		4,430	4,430	WORKMAN'S	64,440
4420			LIABILITY INSURANCE	55,275	55,275	26	3	0	0		4,435	4,435	W/C-FIRST A	793
4425			INSURANCE-OWNERS			22	3	21	0		4,436	4,436	DRUG TESTI	2,449
4430			WORKMENS COMP INSURAI	67,682		22	3	0	0		4,450	4,450	MANAGEME	289,535
4450			CENTRAL OFFICE FEES	289,535		19	3	34	0	**	4,460	4,460	BAD DEBTS	160,382
4460			BAD DEBTS	160,382		27	3	24	-160,382		4,461	4,461	BAD DEBTS	76,998
4470			LOST ITEMS-RESIDENTS	0		27	3	0			4,470	4,470	LOST ITEMS-	0
4490			MISCELLANEOUS	0		27	3	0	0		4,475	4,475	UNIFORM EX	(1,504)
4510			REAL ESTATE TAXES	0	0	33	3	0	0		4,486	4,486	M.I.S. Softwar	38,682
4600			LEASED EQUIPMENT	4,910	15,269	35	3	16	0		4,490	4,490	MISC EXPEN	112
5110			MAINTENANCE SALARIES	56,792	62,023	6	1	0	0		4,496	4,496	MISC. M.I.S. I	8,232
5120			MAINTENANCE SICK & VAC	5,231		6	1	0	0		4,510	4,510	REAL ESTAT	0
5130			ELECTRIC	45,774	74,281	5	3	0	0		4,600	4,600	LEASED EQU	4,910
5131			NATURAL GAS	17,377		5	3	0	0		5,110	5,110	MAINTENAN	56,792
5132			HEATING & DEISEL OIL			5	3	0	0		5,120	5,120	MAINTENAN	5,231
5133			WATER & SEWER	11,130		5	3	0	0		5,130	5,130	ELECTRIC	45,774
5134			TRASH COLLECTION	14,155	83,013	6	3	0	0		5,131	5,131	NATURAL G.	17,377
5140			PROPERTY PLANT REPLACI	2,540	48,471	6	2	0	0		5,133	5,133	WATER & SE	11,130
5160			GENERAL REPAIR & MAINT	45,931		6	2	0	0		5,134	5,134	TRASH COLI	14,155
5165			MAINTENANCE CONTRACT	68,858		6	3	0	0		5,140	5,140	PROP/PLANT	2,540
5210			DIETARY WAGES	221,969	236,926	1	1	0	0		5,160	5,160	GENERAL RI	45,931
5220			DIETARY SICK & VAC	14,957		1	1	0	0		5,165	5,165	MAINTENAN	30,176
5240			SALES TAX			2	3	13	0		5,210	5,210	DIETARY W/	221,969
5248			FOOD PURCHASES	220,209	220,209	2	2	0	0		5,220	5,220	DIETARY PT	14,957
5250			SUPPLIES-DISHWASHING	3,027	12,935	1	2	0	0		5,248	5,248	FOOD PURCI	220,097
5260			DIETARY REPLACEMENT	1,241		1	2	0	0		5,250	5,250	SUPPLIES DI	3,027
5270			KITCHEN SUPPLIES-PAPER	8,667		1	2	0	0		5,260	5,260	REPLACEME	1,241
5295			MEAL CREDIT	0		2	2	0	0		5,270	5,270	KITCHEN SU	8,667
5310			LAUNDRY WAGES	38,949	41,622	4	1	0	0		5,295	5,295	MEAL INCOI	0
5340			LAUNDRY SICK & VAC	2,673		4	1	0	0		5,310	5,310	LAUNDRY W	38,949
5370			LAUNDRY REPLACEMENT	7,739	12,772	4	2	0	0		5,340	5,340	LAUNDRY P'	2,673
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		5,370	5,370	REPLACEME	7,739
5390			LAUNDRY SUPPLIES	5,033		4	2	0	0		5,380			0
5410			HOUSEKEEPING WAGES	85,943	91,351	3	1	0	0		5,390	5,390	SUPPLIES	5,033
5440			HOUSEKEEPING SICK & VA(	5,408		3	1	0	0		5,410	5,410	HOUSEKEEP	85,943
5480			HOUSEKEEPING SUPPLIES	25,964	25,964	3	2	0	0		5,440	5,440	HOUSEKEEP	5,408
5490			HOUSEKEEPING SUPPLIES-F	0		3	2	0	0		5,480	5,480	SUPPLIES-CI	25,964
6010			RN WAGES-MEDICARE		1,834,450	10	1	0	0		5,490	5,490	SUPPLIES-H(	0
6020			RN WAGES-NON MEDICARE	340,430		10	1	0	0		6,020	6,020	RN WAGES	340,430
6030			DON WAGES	67,550		10	1	0	0		6,030	6,030	DON WAGES	67,550
6035			ADON	89,758		10	1	0	0		6,035	6,035	ADON WAGE	89,758
6040			RN SICK & VACATION	24,206		10	1	0	0		6,040	6,040	RN PTO & RE	24,206
6110			LPN WAGES-MEDICARE	318,377		10	1	0	0		6,120	6,120	LPN WAGES	318,377
6120			LPN WAGES-NON MEDICAR	0		10	1	0	0		6,140	6,140	LPN PTO & R	24,506
6130			LPN WAGES OTHER			10	1	0	0		6,220	6,220	AIDES WAGI	870,849
6140			LPN SICK & VACATION	24,506		10	1	0	0		6,240	6,240	AIDES PTO &	43,844
6210			AIDE WAGES-MEDICARE			10	1	0	0		6,245			(2,596)
6220			AIDE WAGES-NON MEDICAI	870,849		10	1	0	0		6,246			69,560
6230			WARD CLERKS			10	1	0	0		6,247			16,351
6240			AIDE VACATION & SICK	43,844		10	1	0	0		6,250			2,238
6245			CONTRACT NURSES-RN	-2,596		10	3	0	0		6,255			1,472
6246			CONTRACT NURSES-LPN	69,560		10	3	0	0		6,260			0
6247			CONTRACT NURSES-AIDES	16,351		10	3	0	0		6,270	6,270	REHAB WAG	51,625
6250			NURSE AIDE TRAINING WA(	2,238	2,238	13	1	0	0		6,275	6,275	REHAB PTO /	3,305
6255			NURSE AID TRAINING EXP	1,472	1,472	13	2	0	0		6,290	6,290	NURSING SU	157,162
6260			NURSE AIDE TRAINING REII	0		0	0	0	0		6,295	6,295	NURSING SU	177
6270			REHAB WAGES	51,625		10	1	0	0		6,390	6,390	REPLACEME	22
6275			REHAB SICK & VAC	3,305		10	1	0	0		6,490	6,490	OTHER	435
6280			NURSING DEPT EDUCATION			23	3	0	0		7,280	7,280	DRUG PURCI	343,050
6290			NURSING SUPPLIES	157,162	157,361	10	2	0	0		7,281	7,281	DRUG PURCI	374,394
6295			NURSING SUPPLIES	177		10	2	0	0		7,380	7,380	LABORATOI	17,932
6390			REPLACEMENT-NURSING	22		10	2	0	0		7,391	7,390	X-RAY SERV	(360)
6490			NURSING OTHER	435	89,792	10	3	0	0		7,393			
7280			DRUG PURCHASES	343,050	720,510	39	2	0	0	***	7,510	7,510	ACTIVITIES '	86,786
7281			DRUG PURCHASES-OTHER	374,394		39	2				7,540	7,540	ACTIVITIES I	6,293
7380			LABORATORY SERVICES	17,572	17,572	39	3	0	0		7,590	7,590	ACTIVITIES :	4,931
7410			HOME HEALTH SALARY			39	1	0	0		7,620	7,620	PHYSICAL TI	393,362
7440			HOME HEALTH SICK & VAC			39	1	0	0		7,660	7,660	P.T. SUPPLY	3,066
7450			HOME HEALTH EXPENSES			39	3	0	0		7,710	7,710	SOCIAL SER'	29,988
7510			ACTIVITES WAGES	86,786	93,079	11	1	0	0		7,720	7,720	SOCIAL SER'	1,444
7540			ACTIVITIES SICK & VAC	6,293		11	1	0	0		7,730	7,730	SOCIAL SERVICE-EXPENSES	
7590			ACTIVITIES SUPPLIES	4,931	4,931	11	2	0	0		7,740	7,740	OCCUPATIOI	337,595
7595			ACTIVITIES FEES	0	0	11	3	0	0		7,750			0
7610			PT WAGES			39	1	0	0		7,770	7,770	SPEECH THE	24,396
7611			PT SICK & VACATION			39	1	0	0		7,820	7,820	BEAUTICIAN	7,813
7620			PT FEES	393,362	755,353	39	3	0	0	***	7,890			0
7660			PT SUPPLIES	3,066		39	2	0	0		7,960			0
7710			SOCIAL SERVICE WAGES	29,988	31,432	12	1	0	0		8,120	8,120	INTEREST	0
7720			SOCIAL SERVICE SICK & VA	1,444		12	1	0	0		8,125			49,945
7730			SOCIAL SERVICE EXPENSE!	0	0	12	2	0	0		8,130	8,130	DEPRECIATI	0
7740			OT FEE	337,595		39	3	0	0	***	8,150			0
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510	9,510	INTEREST IN	(2,804)
7770			SPEECH THERAPY FEE	24,396		39	3	0	0	***	9,520	9,520	MISC NON-O	0
7800			BEAUTICIAN WAGES		0	40	1	0	0		9,530	4,220		0
7810			BEAUTICIAN SICK & VAC			40	1	0	0			8,100		481,800
7820			BEAUTICIAN FEES	7,813	7,813	40	3	0	0			9,702		0
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0			5,230		0
7910			VOLUNTEER COORDINATOR			21	1	0	0					(19,988)
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				Expenses Fixed Assets	
8120			INTEREST EXPENSE	49,945	49,945	32	3	14	-2,804					0
8130			DEPRECIATION	0	0	30	3	9	0					
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0				
9510			INTEREST INCOME	-2,804		32	0	10	0					
9520			MISC NON-OPERATING INC(	0		0	0	0	0					
9700			INCOME TAXES	0		0	0	0	0					
				6,715,593	6,879,058									
					163,465									
GRAND TOTALS				-19,988					-282,543					
				(NET INCOME)										
				0										

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	9,259	9,259
IPA	16,997	16,997
medicare	3,054	3,054
		29,310

Heritage Manor Chillicothe
HFS ID# 205412664001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		Add (Subtract)
Reclassification of Provider Participation Fees		
Provider Participation Fee - $1.50	Line 20, Col 3	(59,436)
Provider Assesment Fee - $6.07	Line 20, Col 3	(160,661)
		(220,097)
Provider Participation Fee	Line 42	220,097
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(717,444)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(17,572)
		(735,016)
Ancillary Service Centers	Line 39	735,016