FOR BHF USE

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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: 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 01/01/16 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 Litchfield # 0048900 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 3/25/16

	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	102	Skilled (SNF)	92	34,512	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	92	34,512	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	13,404	7,312	4,498	25,214	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,404	7,312	4,498	25,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.06%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified and days of care provided 4,498

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: 01/01/16 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	193,199	13,036		206,235		206,235	4,813	211,048			1
2	Food Purchase		190,876		190,876		190,876		190,876			2
3	Housekeeping	99,721	30,956		130,677		130,677	35	130,712			3
4	Laundry	45,600	18,819		64,419		64,419		64,419			4
5	Heat and Other Utilities			78,438	78,438		78,438	1,495	79,933			5
6	Maintenance	66,805	32,106	53,328	152,239		152,239	20,136	172,375			6
7	Other (specify):*											7
8	**TOTAL General Services**	405,325	285,793	131,766	822,884		822,884	26,479	849,363			8
	B. Health Care and Programs											
9	Medical Director			29,020	29,020		29,020		29,020			9
10	Nursing and Medical Records	1,439,935	86,940	5,383	1,532,258		1,532,258	(9,901)	1,522,357			10
10a	Therapy		448,427	25,446	473,873	(473,097)	776		776			10a
11	Activities	35,207	856		36,063		36,063		36,063			11
12	Social Services	57,814		1,835	59,649		59,649		59,649			12
13	CNA Training							1,186	1,186			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,532,956	536,223	61,684	2,130,863	(473,097)	1,657,766	(8,715)	1,649,051			16
	C. General Administration											
17	Administrative	81,548			81,548		81,548		81,548			17
18	Directors Fees											18
19	Professional Services			258,230	258,230		258,230	(237,888)	20,342			19
20	Dues, Fees, Subscriptions & Promotions			204,647	204,647	(180,246)	24,401	(5,454)	18,947			20
21	Clerical & General Office Expenses	83,656	14,344	9,910	107,910		107,910	281,033	388,943			21
22	Employee Benefits & Payroll Taxes			367,141	367,141		367,141	37,927	405,068			22
23	Inservice Training & Education			6,847	6,847		6,847	1,163	8,010			23
24	Travel and Seminar			2,697	2,697		2,697	2,302	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,838	42,838		42,838	15,910	58,748			26
27	Other (specify):*			2,395	2,395		2,395	(2,395)				27
28	**TOTAL General Administration**	165,204	14,344	894,705	1,074,253	(180,246)	894,007	92,598	986,605			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,103,485	836,360	1,088,155	4,028,000	(653,343)	3,374,657	110,362	3,485,019			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: 01/01/16 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							230,877	230,877			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,076	43,076		43,076	98,559	141,635			32
33	Real Estate Taxes							74,457	74,457			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(441,077)	5,683			34
35	Rent-Equipment & Vehicles			15,123	15,123		15,123	8,566	23,689			35
36	Other (specify):*											36
37	**TOTAL Ownership**			504,959	504,959		504,959	(28,618)	476,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			710,836	710,836	473,097	1,183,933	(109,621)	1,074,312			39
40	Barber and Beauty Shops		626	9,039	9,665		9,665		9,665			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					180,246	180,246		180,246			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		626	719,875	720,501	653,343	1,373,844	(109,621)	1,264,223			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,103,485	836,986	2,312,989	5,253,460		5,253,460	(27,877)	5,225,583			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: 01/01/16 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	(69)			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	(3,702)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,951)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,395)			24
25	Fund Raising, Advertising and Promotional	(14,639)			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)**	$ (28,756)		$	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)	879		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 879		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (27,877)		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

Heritage Health Litchfield

ID# 0048900

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		(7,951)	19	22
23				23
24		(2,395)	27	24
25		(14,639)	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**	(24,985)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Litchfield **#** 0048900 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	4,813	0	0	0	0	0	0	0	0	4,813	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	35	0	0	0	0	0	0	0	0	35	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,495	0	0	0	0	0	0	0	0	1,495	5
6	Maintenance	0	0	20,136	0	0	0	0	0	0	0	0	20,136	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	26,479	0	0	0	0	0	0	0	0	26,479	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	(10,196)	295	0	0	0	0	0	0	0	0	(9,901)	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	1,186	0	0	0	0	0	0	0	0	1,186	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	(10,196)	1,481	0	0	0	0	0	0	0	0	(8,715)	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	(7,951)	(248,388)	18,451	0	0	0	0	0	0	0	0	(237,888)	19
20	Fees, Subscriptions & Promotions	(14,639)	0	9,185	0	0	0	0	0	0	0	0	(5,454)	20
21	Clerical & General Office Expenses	0	0	281,033	0	0	0	0	0	0	0	0	281,033	21
22	Employee Benefits & Payroll Taxes	0	0	37,927	0	0	0	0	0	0	0	0	37,927	22
23	Inservice Training & Education	0	0	1,163	0	0	0	0	0	0	0	0	1,163	23
24	Travel and Seminar	(3,702)	0	6,004	0	0	0	0	0	0	0	0	2,302	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	15,910	0	0	0	0	0	0	0	0	15,910	26
27	Other (specify):*	(2,395)	0	0	0	0	0	0	0	0	0	0	(2,395)	27
28	**TOTAL General Administration**	(28,687)	(248,388)	369,673	0	0	0	0	0	0	0	0	92,598	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,687)	(258,584)	397,633	0	0	0	0	0	0	0	0	110,362	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Litchfield # 0048900 **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	204,710	0	26,167	0	0	0	0	0	0	0	230,877	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(69)	98,347	0	281	0	0	0	0	0	0	0	98,559	32
33	Real Estate Taxes	0	74,457	0	0	0	0	0	0	0	0	0	74,457	33
34	Rent-Facility & Grounds	0	(446,760)	0	5,683	0	0	0	0	0	0	0	(441,077)	34
35	Rent-Equipment & Vehicles	0	0	0	8,566	0	0	0	0	0	0	0	8,566	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(69)	(69,246)	0	40,697	0	0	0	0	0	0	0	(28,618)	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	(109,621)	0	0	0	0	0	0	0	0	0	(109,621)	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	(109,621)	0	0	0	0	0	0	0	0	0	(109,621)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,756)	(437,451)	397,633	40,697	0	0	0	0	0	0	0	(27,877)	45

Facility Name & ID Number Heritage Health Litchfield # 0048900 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%	$ (10,196)	$ (10,196)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(109,621)	(109,621)	3
4	V	19	Adjustment for Related Organization	248,388	Heritage Operations Group, LLC	0.00%		(248,388)	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		74,457	74,457	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		92,444	92,444	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		204,710	204,710	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			$ 695,148			$ 257,697	$ * (437,451)	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: 01/01/16 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		$	$ 4,813	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					35	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,495	19
20	V	6	Maintenance					20,136	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					295	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,186	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					18,451	31
32	V	20	Fees, Subscription, Promotions					9,185	32
33	V	21	Clerical & General Office Expenses					281,033	33
34	V	22	Employee Benefits & Payroll Taxes					37,927	34
35	V	23	Inservice Training & Education					1,163	35
36	V	24	Travel and Seminar					6,004	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					15,910	38
39	Total			$			$ 0	$ * 397,633	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: 01/01/16 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					26,167	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					281	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,683	20
21	V	35	Rent-Equipment & Vehicles					8,566	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	$ * 40,697	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: 01/01/16 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 Litchfield # 0048900 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	92	$ 4,813	1
2	2	Food Purchase	Beds	2,571	26	0	0	92	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	92	35	3
4	4	Laundry	Beds	2,571	26	0	0	92	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	92	1,495	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	92	20,136	6
7	7	Other	Beds	2,571	26	0	0	92	0	7
8	9	Medical Director	Beds	2,571	26	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	92	295	9
10	11	Activities	Beds	2,571	26	0	0	92	0	10
11	12	Social Service	Beds	2,571	26	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	92	1,186	12
13	14	Program Transportation	Beds	2,571	26	0	0	92	0	13
14	15	Other	Beds	2,571	26	0	0	92	0	14
15	17	Administrative	Beds	2,571	26	0	0	92	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	92	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	92	18,451	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	92	9,185	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	92	281,033	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	92	37,927	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	92	1,163	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	92	6,004	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	92	15,910	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 397,633	25

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$	$	92	$	1
2	30	Depreciation	Beds	2,571	26	731,247		92	26,167	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			92		3
4	32	Interest	Beds	2,571	26	7,851		92	281	4
5	33	Real Estate Taxes	Beds	2,571	26			92		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		92	5,683	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		92	8,566	7
8	36	Other	Beds	2,571	26			92		8
9	38	Medically Nec Transportation	Beds	2,571	26			92		9
10	39	Ancillary Service Centers	Beds	2,571	26			92		10
11	40	Barber and Beauty Shops	Beds	2,571	26			92		11
12	41	Coffee and Gift Shops	Beds	2,571	26			92		12
13	42	Other	Beds	2,571	26			92		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	$		$ 40,697	25

Facility Name & ID Number Heritage Health Litchfield # 0048900 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Busey Bank		x	Mortgage			$	$			$ 92,444	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							43,076	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 141,423	9
	B. Non-Facility Related*											
10	Interest Income										(69)	10
11												11
12	Allocated Corporate										281	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 212	14
15	TOTALS (line 9+line14)						$	$			$ 141,635	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 Litchfield **#** 0048900 **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.)	$	74,457	2
3. Under or (over) accrual (line 2 minus line 1).	$	74,457	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.	$	74,457	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	73,980	8
2012	71,673	9
2013	72,011	10
2014	74,018	11
2015	74,457	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 Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0048900

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.	1504279009		$ 71,185.78	$ 71,186.00
2.	1504278012		$ 233.54	$ 233.00
3.	1504279015		$ 3,037.98	$ 3,038.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,457.30	$ 74,457.00

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 Litchfield # 0048900 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			1996	$ 6,816	1
2					2
3	TOTALS			$ 6,816	3

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	92				$ 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					26,167		26,167			33
34	Book Depreciation					166,220		166,220			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: 01/01/16 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	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	$ 192,387		$ 192,387	$	$	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: 01/01/16 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		$ 3,551,409	$ 192,387		$ 192,387	$	$	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	$ 192,387		$ 192,387	$	$	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: 01/01/16 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		$ 3,845,504	$ 192,387		$ 192,387	$	$	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	$ 192,387		$ 192,387	$	$	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: 01/01/16 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		$ 4,568,204	$ 192,387		$ 192,387	$	$	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	No 2016 Improvements								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	$ 192,387		$ 192,387	$	$	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: 01/01/16 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	$ 793,544	$ 34,053	$ 34,053	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 793,544	$ 34,053	$ 34,053	$		$	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	$	$	$		$	76
77		2008 Grand Caravan	2011	31,061	4,437	4,437				77
78										78
79										79
80	TOTALS			$ 91,876	$ 4,437	$ 4,437	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,531,590	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 230,877	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 230,877	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: 01/01/16 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: $ 15,123 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: 01/01/16 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				
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: 01/01/16 Ending: 12/31/16

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	$		$ 401,533	$		$ 401,533	1
2	Licensed Speech and Language Development Therapist		hrs			36,498			36,498	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			272,805	776		273,581	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				447,651		447,651	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					25,446			25,446	13
14	TOTAL			$		$ 736,282	$ 448,427		$ 1,184,709	14

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

Facility Name & ID Number Heritage Health Litchfield **#** 0048900 **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	$ 17,246	$	1
2	Cash-Patient Deposits	3,754		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,563,640		3
4	Supply Inventory (priced at)	31,564		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,471		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	71,993		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,718,668	$	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)**	$ 1,718,668	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 204,724	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,754		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	253,212		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,729)		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	22,319		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 482,280	$	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)**	$ 482,280	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,236,388	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,718,668	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Litchfield # 0048900 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**	$ 618,945	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 618,945	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	617,443	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)**	$ 617,443	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)**	$ 1,236,388	24 *

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$ 5,325,345	1
2	Discounts and Allowances for all Levels	(2,552,918)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,772,427	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,240,602	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,240,602	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	(801)	12
13	Barber and Beauty Care	9,485	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	848,250	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	871	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 857,805	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	69	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69	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)**	$ 5,870,903	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	822,884	31
32	Health Care	2,130,863	32
33	General Administration	1,074,253	33
	B. Capital Expense		
34	Ownership	504,959	34
	C. Ancillary Expense		
35	Special Cost Centers	720,501	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)***	$ 5,253,460	40
41	**Income before Income Taxes (line 30 minus line 40)****	617,443	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 617,443	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: 01/01/16 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	1,807	1,902	$ 56,971	$ 29.95	1
2	Assistant Director of Nursing	1,731	1,822	44,751	24.56	2
3	Registered Nurses	5,588	5,882	160,357	27.26	3
4	Licensed Practical Nurses	12,670	13,284	303,196	22.82	4
5	CNAs & Orderlies	56,055	59,005	822,386	13.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,736	1,827	52,274	28.61	8
9	Activity Director					9
10	Activity Assistants	2,774	2,920	35,207	12.06	10
11	Social Service Workers	2,726	2,870	57,814	20.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,525	15,290	193,199	12.64	15
16	Dishwashers					16
17	Maintenance Workers	3,377	3,555	66,805	18.79	17
18	Housekeepers	8,540	8,990	99,721	11.09	18
19	Laundry	4,484	4,720	45,600	9.66	19
20	Administrator	1,984	2,088	81,548	39.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,391	3,570	83,656	23.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,388	127,725	$ 2,103,485 *	$ 16.47	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		29,020		36
37	Medical Records Consultant		653		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,587		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		1,835		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 36,095		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: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Bloomfield			$ 81,548
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,548

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	$ 248,388
ADP	Payroll tax processing	1,239
Tango Inc.	ACA compliance	652
Legal adj to Zero		7,951
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 258,230

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,315
Unemployment Compensation Insurance	23,268
FICA Taxes	160,917
Employee Health Insurance	143,300
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	7,341
Central Office Allocation	37,927
TOTAL (agree to Schedule V, line 22, col.8)	$ 405,068

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	4,049
Health Care Worker Background Check	
(Indicate # of checks performed)	1,127
PR	3,686
Dues & Subscriptions	7,856
License & Fees	1,139
Central Office Allocation	9,185
Less: Public Relations Expense	(3,686)
Non-allowable advertising	(4,409)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	589
	378
Seminar Expense	1,730
	2,302
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 Litchfield # 0048900 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. $ **180,246**
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. $ **1,786**

(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	17,246								1,009	1,009	CASH	17,246
1010			CASH IN BANK									1,100	1,100	ACCTS RI	1,624,681
1040			CASH IN BANK-PAYROLL									1,101	1,101	ALLOW. I	(61,041)
1100			ACCOUNTS RECEIVABLE	1,563,640								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	30,471
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	30,471								1,310	1,310	SUPPLIES	31,564
1220			OTHER PREPAID EXPENSES									1,320	1,320	LINEN INVENTORY	
1300			FOOD INVENTORY									1,409	1,409	LAND	0
1310			SUPPLIES INVENTORY	31,564								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	3,754
1490			ACCUM DEPR-BUILDING	0								1,550	1,550	LOAN FE	0
1530			RESIDENT FUNDS	3,754								1,551	1,551	LOAN FEES ADDED	
1550			LOAN FEES	0								1,850	1,850	INTERCO	71,993
1560			REAL ESTATE TAX ESCROW									2,010	2,010	ACCOUN	(204,724)
1575			REIMBURSABLE PURCHASES									2,100	2,095	BONUSES PAYABLE	
1850			INTRACOMPANY	71,993								2,100	2,100	ACCRUEI	(125,171)
2010			ACCOUNTS PAYABLE	-204,724								2,100	2,100	PR CLEARING-BENEFITS	
2095			BONUSES PAYABLE									2,100	2,100	PR CLEARING-LABOR	
2100			ACCRUED PAYROLL	-125,171								2,110	2,110	ACCRUEI	(128,041)
2110			ACCRUED VACATION PAY	-128,041								2,120	2,120	U.C. TAX	0
2120			UC TAXES PAYABLE									2,125	2,125	FICA TAX	1,729
2125			FICA TAX PAYABLE	1,729	1,729							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 GA	0
2260			WAGE GARNISHMENTS									2,300	2,300	ACCRUEI	0
2280			MISC PAYROLL DEDUCTIONS									2,320	2,320	IPA PAYN	(22,319)
2300			ACCRUED INTEREST PAYAI	0								2,350	2,350	REAL ES	0
2310			SALES TAX PAYABLE									2,385			0
2320			IPA PAYMENTS PAYABLE	-22,319								2,400	2,400	CURRENT PORTION OF LT DEBT	
2350			REAL ESTATE TAX PAYABL	0								2,512	2,512	DUE TO F	(3,754)
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	(618,945)
2460			INCOME TAXES PAYABLE											net income	(617,443)
2512			DUE TO RESIDENTS	-3,754											
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	-618,945											
2970			PROFIT/LOSS FOR PERIOD	-617,443											
3007.1			PATIENT DAYS-PRIVATE	7,312								3,007	3,007	PATIENT DA	7,312
3007.2			PATIENT DAYS-IPA	13,404								3,007	3,007	PATIENT DA	13,404
3007.3			PATIENT DAYS-MEDICARE	4,498								3,007	3,007	PATIENT DA	4,498
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 &	-5,284,880		0	0	0	0			3,007			
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0			3,010	3,010	BASIC CHAR	(5,284,880)
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			128,478
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	(37,416)
3080		1	NURSING SUPPLIES-PRIVAT	-37,416		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	(848,250)
3100		17	DRUGS	-848,250		0	0	0	0			3,101			0
3101		17	DRUGS-OTHER									3,110	3,110	PHYSICAL T	(2,240,602)
3110		6	PT-PRIVATE	-2,240,602		0	0	0	0			3,111			0
3111		6	PT-IPA			0	0	0	0			3,112	3,112	PHYSICAL T	0
3112		6	PT-MEDICARE PART A			0	0	0	0			3,113	3,113	PHYSICAL T	0
3113		6	PT-MEDICARE PART B			0	0	0	0			3,140	3,140	LABORATORY INCOME	
3130		1	PUBLIC AID ASSESSMENT I	128,478								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	2,552,918		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	2,450,858
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 SH	(9,485)
3530		13	BEAUTY SHOP	-9,485		0	0	0	0			3,560			801
3560		12	ACTIVITY FUND INCOME	801		0	0	0	0			3,570	3,570		
3570		12	VENDING INCOME/EXPENSI	0		0	0	0	0			3,590	3,590	EQUIPMENT	(3,049)
3580		12	MANAGEMENT FEES			0	0	0	0			3,595	3,595	RESIDENT TI	(871)
3590		1	EQUIPMENT RENTAL	-3,049		0	0	0	0			3,600	3,600	MISC INCOM	0
3595		21	RESIDENT TRANSPORTATIC	-871		0	0	0	0			4,110	4,110	G&A WAGES	77,046
3600		21	MISC INCOME	0		0	0	0	0			4,111	4,111	ADMINISTRA	81,548
4110			GENERAL & ADMINIST WA(	77,046	83,656	21	1	17	0			4,115	4,115	G&A PTO & I	6,610
4111			ADMINISTRATOR WAGES	81,548	81,548	17	1	0	0			4,120	4,120	EMPLOYEE I	8,391
4115			VACATION & SICK - G&A	6,610		21	1	0	0			4,121			
4120	4475		EMPLOYEE BENEFITS	7,341	367,141	22	3	0	0			4,130	4,130	EMPLOYEE S	0
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135	4,135	EMPLOYEE S	0
4130			EMPLOYEE SCHOLORSHIP V	0	128,478	21	1	0	0			4,250	4,250	OFFICE SUPI	4,385
4135			EMPLOYEE SCHOLORSHIP C	0		23	3	0	0			4,255	4,255	POSTAGE	2,405
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260	4,260	TELEPHONE	9,910
4250	4255		OFFICE SUPPLIES	14,344	14,344	21	2	0	0			4,275	4,275	TRAINING &	6,847
4260			TELEPHONE	9,910	9,910	21	3	0	0			4,276			
4275			TRAINING & EMPLOYEE DE	6,847	6,847	23	3	16	0	**		4,280	4,280	GENERAL TI	589
4280			GENERAL TRAVEL	589	2,697	24	3	16	0			4,281	4,281	MEAL EXPEI	378
4281			MEAL EXPENSE FOR TRAVE	378		24	3	19	0			4,285	4,285	EDUCATION	1,730
4285			EDUCATION & SEMINAR	1,730		24	3	19	-3,702	***		4,289	4,289	MEETINGS E	0
4290			HELP WANTED ADVERTISIN	4,049	76,169	20	3	0	0		-51,768	4,290	4,290	HELP WANTI	4,049
4291			PROMOTIONAL ADVERTISI	6,544		20	3	25	-6,544			4,291	4,291	PROMOTION	6,544
4292			PUBLIC RELATIONS	3,686		20	3	25	-3,686			4,292	4,292	PUBLIC REL	3,686
4300			LICENSES & FEES	52,907		20	3	17	0			4,300	4,300	LICENSE & F	52,907
4310			DUES & SUBSCRIPTIONS	7,856		20	3	17	-4,409			4,310	4,310	DUES & SUB	7,856
4320			CONTRIBUTIONS	0		27	3	20	0			4,320	4,320	CONTRIBUTI	0
4350			PROFESSIONAL FEES	9,842	258,230	19	3	22	-7,951			4,350	4,350	PROFESSION	9,842
4355			MEDICAL DIRECTOR	29,020	29,020	9	3	0	0			4,355	4,355	MEDICAL DI	29,020
4360			UTILIZATION REVIEW	0		10	3	0	0			4,362			653
4361			OTHER PHYSICIAN FEES			39	3	0	0			4,363			4,587
4362			MEDICAL RECORDS CONSU	653		10	3	0	0			4,364	4,364	SOCIAL SER	1,835
4363			PHARMACIST FEES	4,587		10	3	0	0			4,370	4,370	TV RENTAL	9,512
4364			SOC SERV/ACT CONSULT	1,835	1,835	12	3	0	0			4,383	4,383	BACKGROUI	1,127
4370			TV RENTAL	9,512		35	3	5	0			4,390	4,390	OTHER TAXI	0
4380			INCOME TAXES		2,395	27	3	26	0			4,400	4,400	PAYROLL T	175,720
4383			BACKGROUND CHECKS	1,127		20	3	26	0			4,401	4,401	PAYROLL T	8,465
4400			PAYROLL TAXES	175,720		22	3	0	0			4,410	4,410	GROUP INSU	143,300
4401			PAYROLL TAXES ADMINIST	8,465		22	3	0	0			4,420	4,420	LIABILITY II	42,838
4410			GROUP INSURANCE	143,300		22	3	0	0			4,430	4,430	WORKMAN'S	31,654
4420			LIABILITY INSURANCE	42,838	42,838	26	3	0	0			4,435	4,435	W/C-FIRST A	0
4425			INSURANCE-OWNERS			22	3	21	0			4,436	4,436	DRUG TESTI	661
4430			WORKMENS COMP INSURAI	32,315		22	3	0	0			4,450	4,450	MANAGEME	248,388
4450			CENTRAL OFFICE FEES	248,388		19	3	34	0	**		4,460	4,460	BAD DEBTS	2,395
4460			BAD DEBTS	2,395		27	3	24	-2,395			4,461	4,461	BAD DEBTS	102,060
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	(1,050)
4510			REAL ESTATE TAXES	0	0	33	3	0	0			4,486	4,486	M.I.S. Softwar	33,942
4600			LEASED EQUIPMENT	5,611	15,123	35	3	16	0			4,490	4,490	MISC EXPEN	187
5110			MAINTENANCE SALARIES	61,373	66,805	6	1	0	0			4,496	4,496	MISC. M.I.S. I	7,554
5120			MAINTENANCE SICK & VAC	5,432		6	1	0	0			4,510	4,510	REAL ESTAT	0
5130			ELECTRIC	48,459	78,438	5	3	0	0			4,600	4,600	LEASED EQU	5,611
5131			NATURAL GAS	7,762		5	3	0	0			5,110	5,110	MAINTENAN	61,373
5132			HEATING & DEISEL OIL			5	3	0	0			5,120	5,120	MAINTENAN	5,432
5133			WATER & SEWER	22,217		5	3	0	0			5,130	5,130	ELECTRIC	48,459
5134			TRASH COLLECTION	5,537	53,328	6	3	0	0			5,131	5,131	NATURAL G	7,762
5140			PROPERTY PLANT REPLACE	2,168	32,106	6	2	0	0			5,133	5,133	WATER & SE	22,217
5160			GENERAL REPAIR & MAINT	29,938		6	2	0	0			5,134	5,134	TRASH COLI	5,537
5165			MAINTENANCE CONTRACT	47,791		6	3	0	0			5,140	5,140	PROP/PLANT	2,168
5210			DIETARY WAGES	178,433	193,199	1	1	0	0			5,160	5,160	GENERAL RI	29,938
5220			DIETARY SICK & VAC	14,766		1	1	0	0			5,165	5,165	MAINTENAN	13,849
5240			SALES TAX			2	3	13	0			5,210	5,210	DIETARY W	178,433
5248			FOOD PURCHASES	192,662	190,876	2	2	0	0			5,220	5,220	DIETARY PT	14,766
5250			SUPPLIES-DISHWASHING	2,935	13,036	1	2	0	0			5,248	5,248	FOOD PURCI	192,475
5260			DIETARY REPLACEMENT	1,647		1	2	0	0			5,250	5,250	SUPPLIES DI	2,935
5270			KITCHEN SUPPLIES-PAPER	8,454		1	2	0	0			5,260	5,260	REPLACEME	1,647
5295			MEAL CREDIT	-1,786		2	2	0	0			5,270	5,270	KITCHEN SU	8,454
5310			LAUNDRY WAGES	42,549	45,600	4	1	0	0			5,295	5,295	MEAL INCOI	(1,786)
5340			LAUNDRY SICK & VAC	3,051		4	1	0	0			5,310	5,310	LAUNDRY W	42,549
5370			LAUNDRY REPLACEMENT	3,670	18,819	4	2	0	0			5,340	5,340	LAUNDRY P	3,051
5380			LAUNDRY REIMBURSEMENT			4	3	0	0			5,370	5,370	REPLACEME	3,670
5390			LAUNDRY SUPPLIES	15,149		4	2	0	0			5,380			
5410			HOUSEKEEPING WAGES	91,853	99,721	3	1	0	0			5,390	5,390	SUPPLIES	15,149
5440			HOUSEKEEPING SICK & VA	7,868		3	1	0	0			5,410	5,410	HOUSEKEEP	91,853
5480			HOUSEKEEPING SUPPLIES	30,956	30,956	3	2	0	0			5,440	5,440	HOUSEKEEP	7,868
5490			HOUSEKEEPING SUPPLIES-F	0		3	2	0	0			5,480	5,480	SUPPLIES-CI	30,956
6010			RN WAGES-MEDICARE		1,439,935	10	1	0	0			5,490	5,490	SUPPLIES-HO	0
6020			RN WAGES-NON MEDICARE	150,967		10	1	0	0			6,020	6,020	RN WAGES	150,967
6030			DON WAGES	56,971		10	1	0	0			6,030	6,030	DON WAGES	56,971
6035			ADON	44,751		10	1	0	0			6,035	6,035	ADON WAGI	44,751
6040			RN SICK & VACATION	9,390		10	1	0	0			6,040	6,040	RN PTO & RI	9,390
6110			LPN WAGES-MEDICARE	278,874		10	1	0	0			6,120	6,120	LPN WAGES	278,874
6120			LPN WAGES-NON MEDICAR	0		10	1	0	0			6,140	6,140	LPN PTO & R	24,322
6130			LPN WAGES OTHER			10	1	0	0			6,220	6,220	AIDES WAGI	759,257
6140			LPN SICK & VACATION	24,322		10	1	0	0			6,240	6,240	AIDES PTO &	63,129
6210			AIDE WAGES-MEDICARE			10	1	0	0			6,245			0
6220			AIDE WAGES-NON MEDICAI	759,257		10	1	0	0			6,246			
6230			WARD CLERKS			10	1	0	0			6,247			
6240			AIDE VACATION & SICK	63,129		10	1	0	0			6,250			0
6245			CONTRACT NURSES-RN	0		10	3	0	0			6,255			0
6246			CONTRACT NURSES-LPN	0		10	3	0	0			6,260			0
6247			CONTRACT NURSES-AIDES	0		10	3	0	0			6,270	6,270	REHAB WAG	49,380
6250			NURSE AIDE TRAINING WA	0	0	13	1	0	0			6,275	6,275	REHAB PTO	2,894
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0			6,290	6,290	NURSING SU	30,156
6260			NURSE AIDE TRAINING REI	0		0	0	0	0			6,295	6,295	NURSING SU	54,767
6270			REHAB WAGES	49,380		10	1	0	0			6,390	6,390	REPLACEME	2,017
6275			REHAB SICK & VAC	2,894		10	1	0	0			6,490	6,490	OTHER	143
6280			NURSING DEPT EDUCATION			23	3	0	0			7,280	7,280	DRUG PURCI	192,269
6290			NURSING SUPPLIES	30,156	86,940	10	2	0	0			7,281	7,281	DRUG PURCI	255,382
6295			NURSING SUPPLIES	54,767		10	2	0	0			7,380	7,380	LABORATOI	14,700
6390			REPLACEMENT-NURSING	2,017		10	2	0	0			7,391	7,390	X-RAY SERV	10,746
6490			NURSING OTHER	143	5,383	10	3	0	0			7,393			
7280			DRUG PURCHASES	192,269	448,427	39	2	0	0	***		7,510	7,510	ACTIVITIES	31,419
7281			DRUG PURCHASES-OTHER	255,382		39	2					7,540	7,540	ACTIVITIES I	3,788
7380			LABORATORY SERVICES	25,446	25,446	39	3	0	0			7,590	7,590	ACTIVITIES	856
7410			HOME HEALTH SALARY			39	1	0	0			7,620	7,620	PHYSICAL T	272,805
7440			HOME HEALTH SICK & VAC			39	1	0	0			7,660	7,660	P.T. SUPPLY	776
7450			HOME HEALTH EXPENSES			39	3	0	0			7,710	7,710	SOCIAL SER	52,584
7510			ACTIVITES WAGES	31,419	35,207	11	1	0	0			7,720	7,720	SOCIAL SER	5,230
7540			ACTIVITIES SICK & VAC	3,788		11	1	0	0			7,730	7,730	SOCIAL SERVICE-EXPENSES	
7590			ACTIVITIES SUPPLIES	856	856	11	2	0	0			7,740	7,740	OCCUPATIO	401,533
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	36,498
7611			PT SICK & VACATION			39	1	0	0			7,820	7,820	BEAUTICIAN	9,039
7620			PT FEES	272,805	710,836	39	3	0	0	***		7,890			626
7660			PT SUPPLIES	776		39	2	0	0			7,960			0
7710			SOCIAL SERVICE WAGES	52,584	57,814	12	1	0	0			8,120	8,120	INTEREST	0
7720			SOCIAL SERVICE SICK & VA	5,230		12	1	0	0			8,125			43,076
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0			8,130	8,130	DEPRECIATI	0
7740			OT FEE	401,533		39	3	0	0	***		8,150			0
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0			9,510	9,510	INTEREST IN	(69)
7770			SPEECH THERAPY FEE	36,498		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		446,760
7820			BEAUTICIAN FEES	9,039	9,039	40	3	0	0				9,702		0
7890			BEAUTY SHOP SUPPLIES	626	626	40	2	0	0				5,230		0
7910			VOLUNTEER COORDINATOR			21	1	0	0						(617,443)
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					Expenses Fixed Assets	
8120			INTEREST EXPENSE	43,076	43,076	32	3	14	-69						0
8130			DEPRECIATION	0	0	30	3	9	0						
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		0				
9510			INTEREST INCOME	-69		32	0	10	0						
9520			MISC NON-OPERATING INC	0		0	0	0	0						
9700			INCOME TAXES	0		0	0	0	0						
				5,124,913	5,253,460										
					128,547										
GRAND TOTALS				-617,443					-28,756						
				(NET INCOME)											
				0											
			FACILITY NAME:												
			FACILITY ID:	0											
			FACILITY UNITS:	89											
			BALANCE SHEET TOTAL	0											

	G/L	RECAP CENSUS
PP	7,312	7,312
IPA	13,404	13,404
medicare	4,498	4,498
		25,214

Heritage Manor Litchfield
HFS ID# 203904134001
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	(51,768)
Provider Assesment Fee - $6.07	Line 20, Col 3	(128,478)
		(180,246)
Provider Participation Fee	Line 42	180,246
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(447,651)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(25,446)
		(473,097)
Ancillary Service Centers	Line 39	473,097