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: 0048876

Facility Name: Heritage Health Staunton

Address: 215 W Pennsylvania (Number) Staunton (City) 62088 (Zip Code)

County: Macoupin

Telephone Number: (618) 635-5577 Fax # ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

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

IRS Exemption Code

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 Staunton # 0048876 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	90	33,696	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	99	TOTALS	90	33,696	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,453	9,348	2,535	23,336	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,453	9,348	2,535	23,336	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.25%

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 2,535

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 Staunton # 0048876 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	165,190	8,367		173,557		173,557	4,708	178,265			1
2	Food Purchase		145,616		145,616		145,616		145,616			2
3	Housekeeping	111,614	24,259		135,873		135,873	34	135,907			3
4	Laundry	38,942	13,198		52,140		52,140		52,140			4
5	Heat and Other Utilities			91,761	91,761		91,761	1,463	93,224			5
6	Maintenance	51,121	60,494	51,528	163,143		163,143	19,698	182,841			6
7	Other (specify):*											7
8	**TOTAL General Services**	366,867	251,934	143,289	762,090		762,090	25,903	787,993			8
	B. Health Care and Programs											
9	Medical Director			21,025	21,025		21,025		21,025			9
10	Nursing and Medical Records	1,314,721	87,114	107,659	1,509,494		1,509,494	(14,678)	1,494,816			10
10a	Therapy		423,119	14,248	437,367	(436,712)	655		655			10a
11	Activities	47,936	6,113		54,049		54,049		54,049			11
12	Social Services	39,480		2,216	41,696		41,696		41,696			12
13	CNA Training	4,965	2,070		7,035		7,035	1,160	8,195			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,407,102	518,416	145,148	2,070,666	(436,712)	1,633,954	(13,518)	1,620,436			16
	C. General Administration											
17	Administrative	90,780			90,780		90,780		90,780			17
18	Directors Fees											18
19	Professional Services			241,881	241,881		241,881	(218,612)	23,269			19
20	Dues, Fees, Subscriptions & Promotions			208,508	208,508	(181,425)	27,083	(3,907)	23,176			20
21	Clerical & General Office Expenses	97,309	17,161	7,840	122,310		122,310	274,923	397,233			21
22	Employee Benefits & Payroll Taxes			365,201	365,201		365,201	37,103	402,304			22
23	Inservice Training & Education			5,608	5,608		5,608	1,137	6,745			23
24	Travel and Seminar			3,500	3,500		3,500	1,499	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,743	42,743		42,743	15,564	58,307			26
27	Other (specify):*			57,916	57,916		57,916	(57,916)				27
28	**TOTAL General Administration**	188,089	17,161	933,197	1,138,447	(181,425)	957,022	49,791	1,006,813			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,962,058	787,511	1,221,634	3,971,203	(618,137)	3,353,066	62,176	3,415,242			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation							181,749	181,749			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,038	42,038		42,038	147,681	189,719			32
33	Real Estate Taxes							32,767	32,767			33
34	Rent-Facility & Grounds			433,620	433,620		433,620	(428,060)	5,560			34
35	Rent-Equipment & Vehicles			10,622	10,622		10,622	8,380	19,002			35
36	Other (specify):*											36
37	TOTAL Ownership			486,280	486,280		486,280	(57,483)	428,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			465,745	465,745	436,712	902,457	(85,600)	816,857			39
40	Barber and Beauty Shops		355	14,070	14,425		14,425		14,425			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					181,425	181,425		181,425			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		355	479,815	480,170	618,137	1,098,307	(85,600)	1,012,707			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,962,058	787,866	2,187,729	4,937,653		4,937,653	(80,907)	4,856,746			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 Staunton # 0048876 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	(110)			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	(4,374)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,364)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,916)			24
25	Fund Raising, Advertising and Promotional	(12,892)			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)**	$ (101,656)		$	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)	20,749		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 20,749		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (80,907)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heritage Health Staunton

ID# 0048876

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		(26,364)	19	22
23				23
24		(57,916)	27	24
25		(12,892)	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	(97,172)		49

STATE OF ILLINOIS | Summary A

Facility Name & ID Number Heritage Health Staunton # 0048876 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 A. General Services	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)	
1	Dietary	0	0	4,708	0	0	0	0	0	0	0	0	4,708	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	34	0	0	0	0	0	0	0	0	34	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,463	0	0	0	0	0	0	0	0	1,463	5
6	Maintenance	0	0	19,698	0	0	0	0	0	0	0	0	19,698	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	25,903	0	0	0	0	0	0	0	0	25,903	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	(14,967)	289	0	0	0	0	0	0	0	0	(14,678)	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	1,160	0	0	0	0	0	0	0	0	1,160	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	(14,967)	1,449	0	0	0	0	0	0	0	0	(13,518)	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	(26,364)	(210,298)	18,050	0	0	0	0	0	0	0	0	(218,612)	19
20	Fees, Subscriptions & Promotions	(12,892)	0	8,985	0	0	0	0	0	0	0	0	(3,907)	20
21	Clerical & General Office Expenses	0	0	274,923	0	0	0	0	0	0	0	0	274,923	21
22	Employee Benefits & Payroll Taxes	0	0	37,103	0	0	0	0	0	0	0	0	37,103	22
23	Inservice Training & Education	0	0	1,137	0	0	0	0	0	0	0	0	1,137	23
24	Travel and Seminar	(4,374)	0	5,873	0	0	0	0	0	0	0	0	1,499	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	15,564	0	0	0	0	0	0	0	0	15,564	26
27	Other (specify):*	(57,916)	0	0	0	0	0	0	0	0	0	0	(57,916)	27
28	**TOTAL General Administration**	(101,546)	(210,298)	361,635	0	0	0	0	0	0	0	0	49,791	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(101,546)	(225,265)	388,987	0	0	0	0	0	0	0	0	62,176	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Staunton # 0048876 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	156,151	0	25,598	0	0	0	0	0	0	0	181,749	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(110)	147,516	0	275	0	0	0	0	0	0	0	147,681	32
33	Real Estate Taxes	0	32,767	0	0	0	0	0	0	0	0	0	32,767	33
34	Rent-Facility & Grounds	0	(433,620)	0	5,560	0	0	0	0	0	0	0	(428,060)	34
35	Rent-Equipment & Vehicles	0	0	0	8,380	0	0	0	0	0	0	0	8,380	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(110)	(97,186)	0	39,813	0	0	0	0	0	0	0	(57,483)	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	(85,600)	0	0	0	0	0	0	0	0	0	(85,600)	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	(85,600)	0	0	0	0	0	0	0	0	0	(85,600)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,656)	(408,051)	388,987	39,813	0	0	0	0	0	0	0	(80,907)	45

Facility Name & ID Number Heritage Health Staunton # 0048876 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. ☐ 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%	$ (14,967)	$ (14,967)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(85,600)	(85,600)	3
4	V	19	Adjustment for Related Organization	210,298	Heritage Operations Group, LLC	0.00%		(210,298)	4
5	V								5
6	V	34	Adjustment for Related Organization	433,620	Heritage Manor Real Estate, LLC	0.00%		(433,620)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		32,767	32,767	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		141,603	141,603	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		156,151	156,151	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,913	5,913	10
11	V								11
12	V								12
13	V								13
14	Total			$ 643,918			$ 235,867	$ * (408,051)	14

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

Facility Name & ID Number Heritage Health Staunton # 0048876 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		$	$ 4,708	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					34	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,463	19
20	V	6	Maintenance					19,698	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					289	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,160	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					18,050	31
32	V	20	Fees, Subscription, Promotions					8,985	32
33	V	21	Clerical & General Office Expenses					274,923	33
34	V	22	Employee Benefits & Payroll Taxes					37,103	34
35	V	23	Inservice Training & Education					1,137	35
36	V	24	Travel and Seminar					5,873	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					15,564	38
39	Total			$			$ 0	$ * 388,987	39

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

Facility Name & ID Number Heritage Health Staunton # 0048876 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					25,598	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					275	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,560	20
21	V	35	Rent-Equipment & Vehicles					8,380	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	$ * 39,813	39

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

Facility Name & ID Number Heritage Health Staunton # 0048876 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	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Heritage Enterprises Inc.	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 Staunton # 0048876 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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	$ 134,491	$ 133,835	90	$ 4,708	1
2	2	Food Purchase	Beds	2,571	26	0	0	90	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	90	34	3
4	4	Laundry	Beds	2,571	26	0	0	90	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	90	1,463	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	90	19,698	6
7	7	Other	Beds	2,571	26	0	0	90	0	7
8	9	Medical Director	Beds	2,571	26	0	0	90	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	90	289	9
10	11	Activities	Beds	2,571	26	0	0	90	0	10
11	12	Social Service	Beds	2,571	26	0	0	90	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	90	1,160	12
13	14	Program Transportation	Beds	2,571	26	0	0	90	0	13
14	15	Other	Beds	2,571	26	0	0	90	0	14
15	17	Administrative	Beds	2,571	26	0	0	90	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	90	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	90	18,050	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	90	8,985	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	90	274,923	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	90	37,103	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	90	1,137	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	90	5,873	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	90	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	90	15,564	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 388,987	25

Facility Name & ID Number Heritage Health Staunton # 0048876 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	$	$	90	$	1
2	30	Depreciation	Beds	2,571	26	731,247		90	25,598	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			90		3
4	32	Interest	Beds	2,571	26	7,851		90	275	4
5	33	Real Estate Taxes	Beds	2,571	26			90		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		90	5,560	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		90	8,380	7
8	36	Other	Beds	2,571	26			90		8
9	38	Medically Nec Transportation	Beds	2,571	26			90		9
10	39	Ancillary Service Centers	Beds	2,571	26			90		10
11	40	Barber and Beauty Shops	Beds	2,571	26			90		11
12	41	Coffee and Gift Shops	Beds	2,571	26			90		12
13	42	Other	Beds	2,571	26			90		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	$		$ 39,813	25

Facility Name & ID Number Heritage Health Staunton # 0048876 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	Bank of America		x	Mortgage			$	$			$ 141,603	1
2	Bank of America		x	Loan Fee Amortization							5,913	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							42,038	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 189,554	9
	B. Non-Facility Related*											
10	Interest Income										(110)	10
11												11
12	Allocated Corporate										275	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 165	14
15	TOTALS (line 9+line14)						$	$			$ 189,719	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 Staunton # 0048876 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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.)	$	32,767	2
3. Under or (over) accrual (line 2 minus line 1).	$	32,767	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.	$	32,767	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	30,613	8
	2012	31,575	9
	2013	31,965	10
	2014	32,557	11
	2015	32,767	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 Staunton COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0048876

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.	0100190300		$ 31,533.80	$ 31,534.00
2.	0100190001		$ 167.42	$ 167.00
3.	0100190000		$ 305.04	$ 305.00
4.	0100190400		$ 761.00	$ 761.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,767.26	$ 32,767.00

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 Staunton # 0048876 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,700 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

None

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$ 53,090	1
2					2
3	TOTALS			$ 53,090	3

Facility Name & ID Number **Heritage Health Staunton** # **0048876** 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	90				$ 2,016,995	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Laundry Room Central A/C			1996	2,869						9
10	Heritage Manor Sign			1996	1,948						10
11	Circulating Pump--Water System			1996	1,232						11
12											12
13	Roof										13
14	Window Replacement			1998	16,818						14
15	Boilers			1998	14,711						15
16				1998	32,278						16
17	Interior Painting--Materials and Labor			1999	7,875						17
18	Underground Storage Tank			1999	15,000						18
19	Plumbing ---Storage Tank			1999	1,032						19
20	Air conditioning Unit			1999	3,312						20
21	Mixing Valve--Water Heater			1999	4,269						21
22											22
23	Water Heater			2000	3,647						23
24	Water Softener			2000	3,271						24
25	Underground Storage Tank			2000							25
26											26
27	Cissell Dryer			2001							27
28	Water Heater			2001	2,967						28
29											29
30											30
31											31
32											32
33	C/O Allocation					25,598		25,598			33
34	Book Depreciation					127,211		127,211			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 Staunton # 0048876 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	Water Heater	2002	$ 4,142	$		$	$	$	37
38	Boiler	2002	6,349						38
39	A/C Unit	2002	3,385						39
40	Storage Tank	2002	864						40
41									41
42	A/C Unit	2003	1,015						42
43	Nurses Call Station	2003	3,774						43
44	A/C Unit	2003	3,385						44
45									45
46	Exterior door	2004	4,634						46
47	Islandaire Units	2004	7,284						47
48	Roof	2004	70,680						48
49									49
50	Ansul System	2005	2,170						50
51	Roof	2005	129,178						51
52	Furnance	2005	1,395						52
53	A/C Unit	2005	7,586						53
54	Energy Management	2005	13,035						54
55	Wall Repair	2005	1,212						55
56	Kitchen Storage	2005	8,791						56
57	Adjustment	2005	(1,090)						57
58	Fire Dampers	2006	2,798						58
59	Cable & Phone wiring	2006	8,477						59
60	Door replacement	2006	1,064						60
61	A/C Unit	2006	12,294						61
62	Driveway blacktop	2006	16,000						62
63	Exterior door	2006	60						63
64	Sanyo Unit	2006	1,830						64
65	Interior paint	2006	5,500						65
66		2006	(8,716)						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,435,320	$ 152,809		$ 152,809	$	$	70

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

Facility Name & ID Number Heritage Health Staunton # 0048876 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		$ 2,435,320	$ 152,809		$ 152,809	$	$	1
2	Interior Rehab-- Paint, floors & Lighting	2007	194,007						2
3	Water Meter	2007	7,953						3
4	Exterior Doors	2007	4,725						4
5	Fire Alarm	2007	41,283						5
6	Boiler	2007	3,473						6
7	HVAC	2007	18,079						7
8	Water Heater	2007	5,508						8
9	Rooftop HVAC	2007	4,290						9
10	Exhaust Fan	2007	500						10
11	adjustments	2007	(15,002)						11
12	HVAC	2008	7,886						12
13	Boiler	2008	37,955						13
14	Nurse Call System	2008	77,001						14
15	Sprinkler System	2008	74,332						15
16									16
17	Flooring Replacement	2009	8,751						17
18									18
19	Conference room paint, flooring & labor	2010	9,876						19
20	Data equipment relocation	2010	10,197						20
21									21
22									22
23	PTAC units	2011	7,228						23
24	Water heater	2011	5,775						24
25	Landscapping	2011	3,200						25
26									26
27	Lighting Upgrade	2012	5,304						27
28	PTAC units	2012	3,742						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,951,383	$ 152,809		$ 152,809	$	$	34

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

Facility Name & ID Number Heritage Health Staunton # 0048876 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		$ 2,951,383	$ 152,809		$ 152,809	$	$	1
2									2
3	Generator Replacement	2013	55,133						3
4	Water Heater	2013	8,737						4
5	PTAC Installations	2013	8,907						5
6	Replace (3) Valve Actuators & Thermostats	2013	6,454						6
7									7
8	Replace (6) PTAC Units	2014	7,581						8
9	Reface (22) Wardrobe Units	2014	29,110						9
10									10
11	Install (2) new hollow metal doors	2015	3,406						11
12	Install security doors with appropriate electronics	2015	22,769						12
13	Replace (6) PTAC units	2015	7,995						13
14	Replace compressor for PT RTU	2015	2,617						14
15	Replace AC rooftop unit for kitchen and dining room	2015	17,051						15
16									16
17	No 2016 Improvements								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)		$ 3,121,143	$ 152,809		$ 152,809	$	$	34

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

Facility Name & ID Number: Heritage Health Staunton # 0048876 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	$ 633,065	$ 26,282	$ 26,282	$		$	71
72	Current Year Purchases	25,308						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 658,373	$ 26,282	$ 26,282	$		$	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 Chevy Uplander van	2012	$ 18,608	$ 2,658	$ 2,658	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 18,608	$ 2,658	$ 2,658	$		$	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)	$ 3,851,214	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,749	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,749	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.

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 [x] NO
16. Rental Amount for movable equipment: $ 10,622 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.

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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? [x] 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		2,070		2,070
3	Classroom Wages (a)		4,965		4,965
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 7,035	$	$ 7,035
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,035			

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 217,029	$		$ 217,029	1
2	Licensed Speech and Language Development Therapist		hrs			17,704			17,704	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			231,012	655		231,667	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				422,464		422,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,248			14,248	13
14	TOTAL			$		$ 479,993	$ 423,119		$ 903,112	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.

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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	$ 457	$	1
2	Cash-Patient Deposits	14,342		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	837,480		3
4	Supply Inventory (priced at)	11,130		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,450		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	159,042		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,046,901	$	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)**	$ 1,046,901	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 184,516	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,342		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,505		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,856		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	20,608		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 458,827	$	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)**	$ 458,827	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 588,074	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,046,901	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 493,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 493,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	94,751	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)**	$ 94,751	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)**	$ 588,074	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,405,753	1
2	Discounts and Allowances for all Levels	(1,817,868)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,587,885	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,583,496	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,583,496	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	366	12
13	Barber and Beauty Care	9,913	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	844,827	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,807	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 860,913	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	110	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 110	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)**	$ 5,032,404	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	762,090	31
32	Health Care	2,070,666	32
33	General Administration	1,138,447	33
	B. Capital Expense		
34	Ownership	486,280	34
	C. Ancillary Expense		
35	Special Cost Centers	480,170	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)***	$ 4,937,653	40
41	**Income before Income Taxes (line 30 minus line 40)****	94,751	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 94,751	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.

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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	1,684	1,773	$ 63,831	$ 36.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	10,040	10,568	309,588	29.29	3
4	Licensed Practical Nurses	8,940	9,411	223,313	23.73	4
5	CNAs & Orderlies	46,264	48,699	685,445	14.08	5
6	CNA Trainees	560	590	4,965	8.42	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,377	1,449	32,544	22.46	8
9	Activity Director					9
10	Activity Assistants	4,077	4,292	47,936	11.17	10
11	Social Service Workers	1,732	1,823	39,480	21.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,081	13,769	165,190	12.00	15
16	Dishwashers					16
17	Maintenance Workers	2,973	3,130	51,121	16.33	17
18	Housekeepers	9,602	10,107	111,614	11.04	18
19	Laundry	3,824	4,025	38,942	9.68	19
20	Administrator	1,984	2,088	90,780	43.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,935	4,142	97,309	23.49	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)	110,073	115,866	$ 1,962,058 *	$ 16.93	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		21,025		36
37	Medical Records Consultant		594		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,301		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,216		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,136		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		102,722		52
53	TOTAL (lines 50 - 52)		$ 102,722		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joann Newell			$ 90,780
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,780

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	$ 210,298
ADP	Payroll tax processing	1,230
Tango Inc	ACA compliance	514
Cooperative Home Care	Home care consulting	500
Chamlin Associates	Engineering studies	2,975
Legal adj to Zero		26,364
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 241,881

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,645
Unemployment Compensation Insurance	20,602
FICA Taxes	150,097
Employee Health Insurance	120,321
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	14,536
Central Office Allocation	37,103
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,304

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,109
Health Care Worker Background Check (Indicate # of checks performed)	1,412
PR	7,918
Dues & Subscriptions	7,789
License & Fees	1,077
Central Office Allocation	8,985
Less: Public Relations Expense	(7,918)
Non-allowable advertising	(4,196)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,176

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,299
	27
Seminar Expense	2,174
	1,499
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

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. $ **181,425**
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. $ **445**

(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	457					
1010	CASH IN BANK						
1040	CASH IN BANK-PAYROLL						
1100	ACCOUNTS RECEIVABLE	837,480					
1110	MEDICARE RECEIVABLES						
1125	IPA INCOME RECEIVABLE						
1130	MEDICARE COST REPORT						
1135	ACCOUNTS RECEIVABLE-IC						
1140	UNAPPLIED CASH RECEIPTS						
1145	A/R SUSPENSE-REFUNDS						
1190	ACCRUED INTEREST REC						
1200	PREPAID INSURANCE	24,450					
1220	OTHER PREPAID EXPENSES						
1300	FOOD INVENTORY						
1310	SUPPLIES INVENTORY	11,130					
1409	LAND	0					
1450	FURNITURE & EQUIPMENT	0					
1460	ACCUM DEPR-FURN & EQUI	0					
1475	BUILDING & IMPROVEMEN	0					
1490	ACCUM DEPR-BUILDING	0					
1530	RESIDENT FUNDS	14,342					
1550	LOAN FEES	0					
1560	REAL ESTATE TAX ESCROW						
1575	REIMBURSABLE PURCHASES						
1850	INTRACOMPANY	159,042					
2010	ACCOUNTS PAYABLE	-184,516					
2095	BONUSES PAYABLE						
2100	ACCRUED PAYROLL	-112,693					
2110	ACCRUED VACATION PAY	-124,812					
2120	UC TAXES PAYABLE						
2125	FICA TAX PAYABLE	-1,856	-1,856				
2130	FIT PAYABLE						
2140	STATE W/H PAYABLE		0				
2145	EARNED INCOME CREDIT						
2150	UC FED CREDIT REDUCTION						
2230	PAYROLL SAVINGS						
2235	IRA W/HOLDINGS						
2240	UNITED WAY						
2245	GROUP INSURANCE PAYABLE						
2246	GROUP INSURANCE PAYABLE-CAFETERIA						
2260	WAGE GARNISHMENTS						
2280	MISC PAYROLL DEDUCTIONS						
2300	ACCRUED INTEREST PAYAI	0					
2310	SALES TAX PAYABLE						
2320	IPA PAYMENTS PAYABLE	-20,608					
2350	REAL ESTATE TAX PAYABL	0					
2385	ACTIVITY FUND	0					

1,009	1,009	CASH	457
1,100	1,100	ACCTS RI	950,186
1,101	1,101	ALLOW. I	(112,706)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID	24,450
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVENTORY	
1,310	1,310	SUPPLIES	11,130
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITU	0
1,460			0
1,475	1,475	BUILDIN	0
1,490	1,490	ACCUM I	0
1,530	1,530	RESIDEN	14,342
1,550	1,550	LOAN FE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	159,042
2,010	2,010	ACCOUN	(184,516)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEI	(112,693)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEI	(124,812)
2,120	2,120	U.C. TAX	0
2,125	2,125	FICA TAX	(1,856)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE G/	0
2,300	2,300	ACCRUEI	0
2,320	2,320	IPA PAY	(20,608)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO F	(14,342)
2,600	2,600	LASALLE	0

Heritage Manor Staunton
HFS ID# 205437628001
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	(50,544)
Provider Assesment Fee - $6.07	Line 20, Col 3	(130,881)
		(181,425)
Provider Participation Fee	Line 42	181,425
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(422,464)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(14,248)
		(436,712)
Ancillary Service Centers	Line 39	436,712