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: 0048066

Facility Name: Heritage Health Streator

Address: 1525 East Main St (Number) Streator (City) 61364 (Zip Code)

County: LaSalle

Telephone Number: (815) 672-4516 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

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 Streator # 0048066 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 _____

	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	130	Skilled (SNF)	130	47,580	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	130	TOTALS	130	47,580	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	21,967	14,157	5,756	41,880	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,967	14,157	5,756	41,880	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.02%

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 7/2006

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 5,756

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 Streator # 0048066 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	555,402	17,593		572,995		572,995	6,800	579,795			1
2	Food Purchase		109,585		109,585		109,585		109,585			2
3	Housekeeping	159,466	80,074		239,540		239,540	49	239,589			3
4	Laundry	90,939	20,961		111,900		111,900		111,900			4
5	Heat and Other Utilities			144,955	144,955		144,955	2,113	147,068			5
6	Maintenance	86,763	71,817	98,504	257,084		257,084	28,453	285,537			6
7	Other (specify):*											7
8	TOTAL General Services	892,570	300,030	243,459	1,436,059		1,436,059	37,415	1,473,474			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	3,037,689	225,165	10,303	3,273,157		3,273,157	(40,008)	3,233,149			10
10a	Therapy		1,023,071	46,540	1,069,611	(1,068,664)	947		947			10a
11	Activities	73,997	5,697		79,694		79,694		79,694			11
12	Social Services	46,085		4,227	50,312		50,312		50,312			12
13	CNA Training							1,675	1,675			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,157,771	1,253,933	63,470	4,475,174	(1,068,664)	3,406,510	(38,333)	3,368,177			16
	C. General Administration											
17	Administrative	110,000			110,000		110,000		110,000			17
18	Directors Fees											18
19	Professional Services			430,241	430,241		430,241	(401,314)	28,927			19
20	Dues, Fees, Subscriptions & Promotions			335,134	335,134	(290,643)	44,491	(7,665)	36,826			20
21	Clerical & General Office Expenses	268,466	19,118	9,357	296,941		296,941	397,111	694,052			21
22	Employee Benefits & Payroll Taxes			752,892	752,892		752,892	53,593	806,485			22
23	Inservice Training & Education			10,359	10,359		10,359	1,643	12,002			23
24	Travel and Seminar			11,191	11,191		11,191	(6,192)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,038	58,038		58,038	22,482	80,520			26
27	Other (specify):*			138,833	138,833		138,833	(138,833)				27
28	TOTAL General Administration	378,466	19,118	1,746,045	2,143,629	(290,643)	1,852,986	(79,175)	1,773,811			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,428,807	1,573,081	2,052,974	8,054,862	(1,359,307)	6,695,555	(80,093)	6,615,462			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 Streator #0048066 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							309,142	309,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,019	59,019		59,019	86,273	145,292			32
33	Real Estate Taxes							63,739	63,739			33
34	Rent-Facility & Grounds			569,400	569,400		569,400	(561,369)	8,031			34
35	Rent-Equipment & Vehicles			32,884	32,884		32,884	12,104	44,988			35
36	Other (specify):*											36
37	TOTAL Ownership			661,303	661,303		661,303	(90,111)	571,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			889,959	889,959	1,068,664	1,958,623	(276,361)	1,682,262			39
40	Barber and Beauty Shops		954	16,452	17,406		17,406		17,406			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					290,643	290,643		290,643			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		954	906,411	907,365	1,359,307	2,266,672	(276,361)	1,990,311			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,428,807	1,574,035	3,620,688	9,623,530		9,623,530	(446,565)	9,176,965			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 Streator # 0048066 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	(847)			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	(14,675)			19
20	Contributions	(1,549)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,102)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,284)			24
25	Fund Raising, Advertising and Promotional	(20,644)			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)**	$ (183,101)		$	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)	(263,464)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (263,464)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (446,565)		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 Streator

ID# 0048066

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			27	20
21				21
22		(8,102)	19	22
23				23
24		(137,284)	27	24
25		(20,644)	20	25
26				26
27		(1,549)	27	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**	(167,579)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Streator **#** 0048066 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	6,800	0	0	0	0	0	0	0	0	6,800	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	49	0	0	0	0	0	0	0	0	49	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,113	0	0	0	0	0	0	0	0	2,113	5
6	Maintenance	0	0	28,453	0	0	0	0	0	0	0	0	28,453	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	37,415	0	0	0	0	0	0	0	0	37,415	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	(40,425)	417	0	0	0	0	0	0	0	0	(40,008)	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	1,675	0	0	0	0	0	0	0	0	1,675	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	(40,425)	2,092	0	0	0	0	0	0	0	0	(38,333)	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	(8,102)	(419,284)	26,072	0	0	0	0	0	0	0	0	(401,314)	19
20	Fees, Subscriptions & Promotions	(20,644)	0	12,979	0	0	0	0	0	0	0	0	(7,665)	20
21	Clerical & General Office Expenses	0	0	397,111	0	0	0	0	0	0	0	0	397,111	21
22	Employee Benefits & Payroll Taxes	0	0	53,593	0	0	0	0	0	0	0	0	53,593	22
23	Inservice Training & Education	0	0	1,643	0	0	0	0	0	0	0	0	1,643	23
24	Travel and Seminar	(14,675)	0	8,483	0	0	0	0	0	0	0	0	(6,192)	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	22,482	0	0	0	0	0	0	0	0	22,482	26
27	Other (specify):*	(138,833)	0	0	0	0	0	0	0	0	0	0	(138,833)	27
28	**TOTAL General Administration**	(182,254)	(419,284)	522,363	0	0	0	0	0	0	0	0	(79,175)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(182,254)	(459,709)	561,870	0	0	0	0	0	0	0	0	(80,093)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Streator # 0048066 **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	272,167	0	36,975	0	0	0	0	0	0	0	309,142	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(847)	86,723	0	397	0	0	0	0	0	0	0	86,273	32
33	Real Estate Taxes	0	63,739	0	0	0	0	0	0	0	0	0	63,739	33
34	Rent-Facility & Grounds	0	(569,400)	0	8,031	0	0	0	0	0	0	0	(561,369)	34
35	Rent-Equipment & Vehicles	0	0	0	12,104	0	0	0	0	0	0	0	12,104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(847)	(146,771)	0	57,507	0	0	0	0	0	0	0	(90,111)	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	(276,361)	0	0	0	0	0	0	0	0	0	(276,361)	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	(276,361)	0	0	0	0	0	0	0	0	0	(276,361)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(183,101)	(882,841)	561,870	57,507	0	0	0	0	0	0	0	(446,565)	45

Facility Name & ID Number Heritage Health Streator # 0048066 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%	$ (40,425)	$ (40,425)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(276,361)	(276,361)	3
4	V	19	Adjustment for Related Organization	419,284	Heritage Operations Group, LLC	0.00%		(419,284)	4
5	V								5
6	V	34	Adjustment for Related Organization	569,400	Heritage Manor Real Estate, LLC	0.00%		(569,400)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		63,739	63,739	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		82,785	82,785	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		272,167	272,167	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		3,938	3,938	10
11	V								11
12	V								12
13	V								13
14	Total			$ 988,684			$ 105,843	$ * (882,841)	14

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

Facility Name & ID Number Heritage Health Streator # 0048066 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		$	$ 6,800	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					49	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					2,113	19
20	V	6	Maintenance					28,453	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					417	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,675	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					26,072	31
32	V	20	Fees, Subscription, Promotions					12,979	32
33	V	21	Clerical & General Office Expenses					397,111	33
34	V	22	Employee Benefits & Payroll Taxes					53,593	34
35	V	23	Inservice Training & Education					1,643	35
36	V	24	Travel and Seminar					8,483	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					22,482	38
39	Total			$			$ 0	$ * 561,870	39

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

Facility Name & ID Number Heritage Health Streator # 0048066 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. ☐ 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					36,975	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					397	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					8,031	20
21	V	35	Rent-Equipment & Vehicles					12,104	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	$ * 57,507	39

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

Facility Name & ID Number Heritage Health Streator # 0048066 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 Streator # 0048066 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	130	$ 6,800	1
2	2	Food Purchase	Beds	2,571	26	0	0	130	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	130	49	3
4	4	Laundry	Beds	2,571	26	0	0	130	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	130	2,113	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	130	28,453	6
7	7	Other	Beds	2,571	26	0	0	130	0	7
8	9	Medical Director	Beds	2,571	26	0	0	130	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	130	417	9
10	11	Activities	Beds	2,571	26	0	0	130	0	10
11	12	Social Service	Beds	2,571	26	0	0	130	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	130	1,675	12
13	14	Program Transportation	Beds	2,571	26	0	0	130	0	13
14	15	Other	Beds	2,571	26	0	0	130	0	14
15	17	Administrative	Beds	2,571	26	0	0	130	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	130	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	130	26,072	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	130	12,979	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	130	397,111	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	130	53,593	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	130	1,643	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	130	8,483	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	130	22,482	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 561,870	25

Facility Name & ID Number Heritage Health Streator # 0048066 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	$	$	130	$	1
2	30	Depreciation	Beds	2,571	26	731,247		130	36,975	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			130		3
4	32	Interest	Beds	2,571	26	7,851		130	397	4
5	33	Real Estate Taxes	Beds	2,571	26			130		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		130	8,031	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		130	12,104	7
8	36	Other	Beds	2,571	26			130		8
9	38	Medically Nec Transportation	Beds	2,571	26			130		9
10	39	Ancillary Service Centers	Beds	2,571	26			130		10
11	40	Barber and Beauty Shops	Beds	2,571	26			130		11
12	41	Coffee and Gift Shops	Beds	2,571	26			130		12
13	42	Other	Beds	2,571	26			130		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	$		$ 57,507	25

Facility Name & ID Number Heritage Health Streator # 0048066 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			$	$			$ 82,785	1
2	Bank of America		x	Loan Fee Amortization							3,938	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							59,019	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 145,742	9
	B. Non-Facility Related*											
10	Interest Income										(847)	10
11												11
12	Allocated Corporate										397	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (450)	14
15	TOTALS (line 9+line14)						$	$			$ 145,292	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 Streator # 0048066 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.)	$	63,739	2
3. Under or (over) accrual (line 2 minus line 1).	$	63,739	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.	$	63,739	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	64,367	8
2012	61,277	9
2013	64,107	10
2014	63,649	11
2015		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 Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048066

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.	34-31-134-000		$ 63,739.16	$ 63,739.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,739.16	$ 63,739.00

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 Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,770 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

Evergreen Place-Streator - (53) unit supportive living facility - grounds are adjacent but separate.

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				$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Heritage Health Streator # 0048066 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	130				$ 348,848	$		$	$	$	4
5					440,122						5
6					2,594,839						6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	1980 Improvements			1980	12,172						11
12	1981 Improvements			1981	13,748						12
13	1982 Improvements			1982	18,366						13
14	1983 Improvements			1983	9,250						14
15	1984 Improvements			1984	1,329						15
16	1985 Improvements			1985	4,100						16
17	1986 Improvements			1986	57,336						17
18	1988 Improvements			1987	6,225						18
19	1989 Improvements			1988	48,818						19
20	1990 Improvements			1989	22,687						20
21	1991 Improvements			1990	31,584						21
22	1992 Improvements			1991	3,560						22
23	1993 Improvements			1992	19,172						23
24	1994 Improvements			1993	23,135						24
25	1995 Improvements			1994	22,036						25
26	BOILER			1995	39,228						26
27	EXHAUST HOOD			1996	3,910						27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation					36,975		36,975			33
34	Book Depreciation					201,463		201,463			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 Streator # 0048066 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	Interior Rehab---Facility	1997	$ 286,974	$		$	$	$	37
38	Roof	1997	5,232						38
39	Sprinkler System	1997	9,530						39
40	Code Alert	1997	1,879						40
41									41
42	Code Alert	1998	2,000						42
43	Bathroom Door	1998	656						43
44	Interior Rehab	1998	11,815						44
45									45
46	Door Alarms	1999	3,675						46
47									47
48	Water Heater	2000	4,114						48
49	Exhaust Fans	2000	931						49
50	Booster Heater -- Water Heater	2000	1,465						50
51									51
52	Professional Fees---Building Renovation	2001	27,964						52
53	Sprinkler Replacement	2001	4,955						53
54	AC Unit with Installation	2001	4,372						54
55	Exterior Painting	2001	6,545						55
56	Code Alert System	2001	4,592						56
57									57
58	Roof	2002	48,840						58
59	Sewer line	2002	20,615						59
60	Condensing Unit	2002	1,213						60
61									61
62	Exterior Door	2003	6,556						62
63	Exit Lights	2003	1,013						63
64	Heating Pump	2003	1,746						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,177,147	$ 238,438		$ 238,438	$	$	70

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

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,177,147	$ 238,438		$ 238,438	$	$	1
2	Doors	2004	1,386						2
3	A/C	2004	5,061						3
4	PVC kickplate	2004	2,859						4
5	Disposal	2004	1,175						5
6									6
7	Roof	2005	54,596						7
8	A/C Condensing Unit	2005	5,800						8
9	Window Replacement	2005	51,893						9
10	Water Main	2005	1,706						10
11									11
12									12
13	Roof	2006	19,500						13
14	A/C Replacement	2006	1,974						14
15	Boiler	2006	58,327						15
16	Landscapping	2006	5,398						16
17									17
18	Nurse's station	2007	9,580						18
19	Nurse call system	2007	96,193						19
20	Wireless network	2007	26,272						20
21	Corridor Paint and floors	2007	37,819						21
22	A/C	2007	23,747						22
23	Wander guard	2007	4,177						23
24	Garage --Construction of new Maintenance Garage	2007	42,453						24
25	Professional Fee -- remodel	2007	1,286						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,628,349	$ 238,438		$ 238,438	$	$	34

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

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,628,349	$ 238,438		$ 238,438	$	$	1
2	Landscaping	2008	22,238						2
3	Garage --Construction of new Maintenance Garage	2008	9,644						3
4	South Wing Windows	2008	63,040						4
5	Air Handler	2008	10,301						5
6	Redo North Nurses Station	2008	8,101						6
7									7
8	Wireless Network	2009	4,035						8
9	South Dining Room Electric	2009	2,752						9
10	Corridor Doors	2009	22,230						10
11									11
12	Lennox condensor	2010	6,864						12
13	Walkin Cooler	2010	4,313						13
14	Nurse Call System	2010	6,594						14
15	Wood Blinds	2010	2,914						15
16									16
17									17
18	Trane Air Handler	2011	58,281						18
19	Trane Rooftop Unit	2011	3,017						19
20	Gas Water Heater	2011	4,352						20
21	Air Condition Coils	2011	7,904						21
22	Water Heater	2011	4,352						22
23	Wiring & Installation	2011	7,546						23
24	Sealer & Coating	2011	8,985						24
25	Sign	2011	2,650						25
26									26
27	Goodman Condensing Unit	2012	9,494						27
28	Flooring Replacement	2012	176,220						28
29	GFI & Receptical	2012	4,158						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,078,334	$ 238,438		$ 238,438	$	$	34

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

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,078,334	$ 238,438		$ 238,438	$	$	1
2	Lighting Retrofit-Faciltiy wide replacement of ballasts and bulbs	2013	8,250						2
3	Renovation of rooms & hallways in corridors 300 & 400	2013	229,287						3
4	(Removal and replacement of flooring and cabinets; painting)	2014	87,266						4
5									5
6	Renovation of rooms & hallways in corridors 100 & 200								6
7	(Removal and replacement of flooring and cabinets; painting)	2014	235,862						7
8	Water Heater Replacement	2014	17,378						8
9	Install Electric Door	2014	6,242						9
10	Parking Lot Fill and Seal	2014	6,863						10
11									11
12	Installed (2) new hot water heater expansion tanks	2015	3,785						12
13	Install electric heat in air handlers - NE and NW wings	2015	9,295						13
14	Completion of 2014 renovation to corridors 100&200 -	2015	3,650						14
15	asbestos abatement								15
16	Replace (4) wood doors	2015	3,440						16
17	Flooring replacement - Rec Room	2015	5,334						17
18	Nurse call system upgrade - telephonic and electrical upgrades	2015	33,961						18
19									19
20	No 2016 Improvements								20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,728,947	$ 238,438		$ 238,438	$	$	34

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

Facility Name & ID Number Heritage Health Streator # 0048066 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	$	$ 63,326	$ 63,326	$		$	71
72	Current Year Purchases	17,113						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 17,113	$ 63,326	$ 63,326	$		$	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		2017 Dodge Grand SW	2016	$ 43,540	$ 1,555	$ 1,555	$		$	76
77		2009 Turtletop Bus	2008	40,760	5,823	5,823				77
78										78
79										79
80	TOTALS			$ 84,300	$ 7,378	$ 7,378	$		$	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)	$ 5,880,360	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 309,142	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 309,142	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 Streator # 0048066 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: $ 32,884 Description: Supplies, copiers and televisions
(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 Streator # 0048066 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 Streator

STATE OF ILLINOIS
0048066 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	$		$ 455,068	$		$ 455,068	1
2	Licensed Speech and Language Development Therapist		hrs			53,644			53,644	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			381,247	947		382,194	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				1,022,124		1,022,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					46,540			46,540	13
14	TOTAL			$		$ 936,499	$ 1,023,071		$ 1,959,570	14

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Streator **#** 0048066 **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	$ 13,385	$	1
2	Cash-Patient Deposits	9,647		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,284,628		3
4	Supply Inventory (priced at)	27,346		4
5	Short-Term Investments			5
6	Prepaid Insurance	42,855		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(382,361)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,995,500	$	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)**	$ 1,995,500	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 285,150	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,647		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	354,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,522		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	37,373		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 698,127	$	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)**	$ 698,127	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,297,373	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,995,500	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Streator # 0048066 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**	$ 902,564	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 902,564	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,809	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)**	$ 394,809	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)**	$ 1,297,373	24 *

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

Facility Name & ID Number Heritage Health Streator # 0048066 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	$ 9,011,807	1
2	Discounts and Allowances for all Levels	(4,016,190)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,995,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,075,499	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,075,499	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		12
13	Barber and Beauty Care	19,796	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,881,953	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	44,627	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,946,376	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	847	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 847	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)**	$ 10,018,339	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,436,059	31
32	Health Care	4,475,174	32
33	General Administration	2,143,629	33
	B. Capital Expense		
34	Ownership	661,303	34
	C. Ancillary Expense		
35	Special Cost Centers	907,365	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)***	$ 9,623,530	40
41	**Income before Income Taxes (line 30 minus line 40)****	394,809	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 394,809	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 Streator # 0048066 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	1,783	1,877	$ 73,358	$ 39.08	1
2	Assistant Director of Nursing	1,739	1,831	60,851	33.23	2
3	Registered Nurses	23,041	24,254	780,242	32.17	3
4	Licensed Practical Nurses	18,612	19,592	556,976	28.43	4
5	CNAs & Orderlies	91,339	96,146	1,441,886	15.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,890	4,095	124,376	30.37	8
9	Activity Director					9
10	Activity Assistants	4,906	5,164	73,997	14.33	10
11	Social Service Workers	1,872	1,971	46,085	23.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	47,432	49,929	555,402	11.12	15
16	Dishwashers					16
17	Maintenance Workers	4,838	5,093	86,763	17.04	17
18	Housekeepers	13,859	14,588	159,466	10.93	18
19	Laundry	7,404	7,794	90,939	11.67	19
20	Administrator	1,984	2,088	110,000	52.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,487	13,144	268,466	20.42	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)	235,186	247,566	$ 4,428,807 *	$ 17.89	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		2,400		36
37	Medical Records Consultant		353		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,735		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		3,815		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,303		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 Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie Bradley			$ 110,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group		$ 419,283
ADP	Payroll Tax Processing	1,557
Tango Inc	ACA Compliance	1,299
Legal adj to Zero		8,102
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 430,241

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,269
Unemployment Compensation Insurance	47,974
FICA Taxes	338,804
Employee Health Insurance	251,429
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	41,416
Central Office Allocation	53,593
TOTAL (agree to Schedule V, line 22, col.8)	$ 806,485

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	8,146
Health Care Worker Background Check	
(Indicate # of checks performed)	5,665
PR	10,653
Dues & Subscriptions	11,456
License & Fees	5,115
Central Office Allocation	12,979
Less: Public Relations Expense	(10,653)
Non-allowable advertising	(6,535)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,826

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	7,645
	27
Seminar Expense	3,519
	(6,192)
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 Streator # 0048066 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. $ **290,643**
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. $ **236,078**

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

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

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

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

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount	
1009			PETTY CASH	13,385						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	2,284,628						
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	42,855						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY							
1310			SUPPLIES INVENTORY	27,346						
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	0						
1460			ACCUM DEPR-FURN & EQUI	0						
1475			BUILDING & IMPROVEMENT	0						
1490			ACCUM DEPR-BUILDING	0						
1530			RESIDENT FUNDS	9,647						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	-382,361						
2010			ACCOUNTS PAYABLE	-285,150						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-93,406						
2110			ACCRUED VACATION PAY	-261,029						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-11,522	-11,522					
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	-37,373						
2350			REAL ESTATE TAX PAYABL	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS	0						
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-9,647						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-902,564						
2970			PROFIT/LOSS FOR PERIOD	-394,809						
3007.1			PATIENT DAYS-PRIVATE	14,157						
3007.2			PATIENT DAYS-IPA	21,967						
3007.3			PATIENT DAYS-MEDICARE	5,756						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE &	-8,907,867		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	0		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE			0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVAT	-95,180		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-1,881,953		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-3,075,499		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT II	219,273						
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	4,016,190		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-19,796		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12	VENDING INCOME/EXPENSI	0		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-8,760		0	0	0	0	
3595		21	RESIDENT TRANSPORTATIC	-44,652		0	0	0	0	
3600		21	MISC INCOME	25		0	0	0	0	
4110			GENERAL & ADMINIST WAC	231,881	268,466	21	1	17	0	
4111			ADMINISTRATOR WAGES	110,000	110,000	17	1	0	0	
4115			VACATION & SICK - G&A	36,585		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	34,266	752,892	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACO	0		22	3	0	0	
4130			EMPLOYEE SCHOLORSHIP V	3,623	219,273	21	1	0	0	
4135			EMPLOYEE SCHOLORSHIP (	3,527		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	19,118	19,118	21	2	0	0	
4260			TELEPHONE	9,357	9,357	21	3	0	0	
4275			TRAINING & EMPLOYEE DE	10,359	10,359	23	3	16	0	**
4280			GENERAL TRAVEL	7,645	11,191	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVE	27		24	3	19	0	
4285			EDUCATION & SEMINAR	3,519		24	3	19	-14,675	***
4290			HELP WANTED ADVERTISIN	8,146	115,861	20	3	0	0	-71,370
4291			PROMOTIONAL ADVERTISII	3,456		20	3	25	-3,456	
4292			PUBLIC RELATIONS	10,653		20	3	25	-10,653	
4300			LICENSES & FEES	76,485		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	11,456		20	3	17	-6,535	
4320			CONTRIBUTIONS	1,549		27	3	27	0	
4350			PROFESSIONAL FEES	10,957	430,241	19	3	22	-8,102	
4355			MEDICAL DIRECTOR	2,400	2,400	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSU	353		10	3	0	0	
4363			PHARMACIST FEES	7,735		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3,815	3,815	12	3	0	0	
4370			TV RENTAL	9,405		35	3	5	0	
4380			INCOME TAXES		138,833	27	3	26	-1,549	
4383			BACKGROUND CHECKS	5,665		20	3	26	0	
4400			PAYROLL TAXES	375,360		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	11,418		22	3	0	0	
4410			GROUP INSURANCE	251,429		22	3	0	0	
4420			LIABILITY INSURANCE	58,038	58,038	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURAI	73,269		22	3	0	0	
4450			CENTRAL OFFICE FEES	419,284		19	3	34	0	**
4460			BAD DEBTS	137,284		27	3	24	-137,284	
4470			LOST ITEMS-RESIDENTS	0		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	23,479	32,884	35	3	16	0	
5110			MAINTENANCE SALARIES	80,167	86,763	6	1	0	0	
5120			MAINTENANCE SICK & VAC	6,596		6	1	0	0	
5130			ELECTRIC	78,378	144,955	5	3	0	0	
5131			NATURAL GAS	25,690		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	40,887		5	3	0	0	
5134			TRASH COLLECTION	16,417	98,504	6	3	0	0	
5140			PROPERTY PLANT REPLACI	24,476	71,817	6	2	0	0	
5160			GENERAL REPAIR & MAINT	47,341		6	2	0	0	
5165			MAINTENANCE CONTRACT	82,087		6	3	0	0	
5210			DIETARY WAGES	515,103	555,402	1	1	0	0	
5220			DIETARY SICK & VAC	40,299		1	1	0	0	
5240			SALES TAX			2	3	13	0	
5248			FOOD PURCHASES	345,663	109,585	2	2	0	0	
5250			SUPPLIES-DISHWASHING	4,449	17,593	1	2	0	0	
5260			DIETARY REPLACEMENT	2,032		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	11,112		1	2	0	0	
5295			MEAL CREDIT	-236,078		2	2	0	0	
5310			LAUNDRY WAGES	84,670	90,939	4	1	0	0	
5340			LAUNDRY SICK & VAC	6,269		4	1	0	0	
5370			LAUNDRY REPLACEMENT	13,375	20,961	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	7,586		4	2	0	0	
5410			HOUSEKEEPING WAGES	145,662	159,466	3	1	0	0	
5440			HOUSEKEEPING SICK & VA(	13,804		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	79,733	80,074	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-I	341		3	2	0	0	
6010			RN WAGES-MEDICARE		3,037,689	10	1	0	0	
6020			RN WAGES-NON MEDICARE	724,098		10	1	0	0	
6030			DON WAGES	73,358		10	1	0	0	
6035			ADON	60,851		10	1	0	0	
6040			RN SICK & VACATION	56,144		10	1	0	0	
6110			LPN WAGES-MEDICARE	510,580		10	1	0	0	
6120			LPN WAGES-NON MEDICAR	0		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	46,396		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICAI	1,352,619		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	89,267		10	1	0	0	
6245			CONTRACT NURSES-RN	0		10	3	0	0	
6246			CONTRACT NURSES-LPN	0		10	3	0	0	
6247			CONTRACT NURSES-AIDES	0		10	3	0	0	
6250			NURSE AIDE TRAINING WAI	0	0	13	1	0	0	
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260			NURSE AIDE TRAINING REII	0		0	0	0	0	
6270			REHAB WAGES	115,504		10	1	0	0	
6275			REHAB SICK & VAC	8,872		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	67,835	225,165	10	2	0	0	
6295			NURSING SUPPLIES	137,654		10	2	0	0	
6390			REPLACEMENT-NURSING	19,676		10	2	0	0	
6490			NURSING OTHER	2,215	10,303	10	3	0	0	
7280			DRUG PURCHASES	444,747	1,023,071	39	2	0	0	***
7281			DRUG PURCHASES-OTHER	577,377		39	2			
7380			LABORATORY SERVICES	46,540	46,540	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	66,829	73,997	11	1	0	0	
7540			ACTIVITIES SICK & VAC	7,168		11	1	0	0	
7590			ACTIVITIES SUPPLIES	5,697	5,697	11	2	0	0	
7595			ACTIVITIES FEES	0	0	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	381,247	889,959	39	3	0	0	***
7660			PT SUPPLIES	947		39	2	0	0	
7710			SOCIAL SERVICE WAGES	43,290	46,085	12	1	0	0	
7720			SOCIAL SERVICE SICK & VA	2,795		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	412	412	12	2	0	0	
7740			OT FEE	455,068		39	3	0	0	***
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	53,644		39	3	0	0	***
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	16,452	16,452	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	954	954	40	2	0	0	
7910			VOLUNTEER COORDINATOR			21	1	0	0	
7940			VOL COORD SICK & VAC			21	1	0	0	
7960			VOL COORD SUPPLIES	0		21	2	0	0	
8100			RENT	569,400	569,400	34	3	0	0	
8120			INTEREST EXPENSE	59,019	59,019	32	3	14	-847	
8130			DEPRECIATION	0	0	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510			INTEREST INCOME	-847		32	0	10	0	
9520			MISC NON-OPERATING INC(	0		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				9,403,410	9,623,530					
					220,120					
GRAND TOTALS				-394,809					-183,101	
				(NET INCOME)						
				0						

1,009	1,009	CASH	13,385
1,100	1,100	ACCTS RI	2,483,304
1,101	1,101	ALLOW. I	(198,676)
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	42,855
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVENTORY	
1,310	1,310	SUPPLIES	27,346
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	9,647
1,550	1,550	LOAN FE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	(382,361)
2,010	2,010	ACCOUN	(285,150)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEI	(93,406)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEI	(261,029)
2,120	2,120	U.C. TAX	0
2,125	2,125	FICA TAX	(11,522)
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 GA	0
2,300	2,300	ACCRUEI	0
2,320	2,320	IPA PAYN	(37,373)
2,350	2,350	REAL EST	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO F	(9,647)
2,600	2,600	LASALLE	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINE	(902,564)
		net income	(394,809)
		balance	0
3,007	3,007	PATIENT DA	14,157
3,007	3,007	PATIENT DA	21,967
3,007	3,007	PATIENT DA	5,756
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHAR	(8,907,867)
3,020	3,020	BASIC CHAR	0
3,030	3,030	BASIC CHAR	0
3,040			219,273
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SU	(95,180)
3,081	3,081	NURSING SU	0
3,082	3,082	NURSING SU	0
3,083	3,083	NURSING SU	0
3,100	3,100	DRUGS-MED	(1,881,953)
3,101			0
3,110	3,110	PHYSICAL TI	(3,075,499)
3,111			0
3,112	3,112	PHYSICAL TI	0
3,113	3,113	PHYSICAL TI	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THER/	0
3,153	3,153	ST/OT THER/	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER I	0
3,411	3,411	MEDICARE F	0
3,420	3,420	MEDICARE I	3,948,906
3,500			
3,520	3,520	RENT INCOM	0
3,530	3,530	BEAUTY SH(	(19,796)
3,560			0
3,570	3,570		
3,590	3,590	EQUIPMENT	(8,760)
3,595	3,595	RESIDENT TI	(44,652)
3,600	3,600	MISC INCOM	25
4,110	4,110	G&A WAGES	231,881
4,111	4,111	ADMINISTRA	110,000
4,115	4,115	G&A PTO & I	36,585
4,120	4,120	EMPLOYEE I	30,867
4,121			
4,130	4,130	EMPLOYEE S	3,623
4,135	4,135	EMPLOYEE S	3,527
4,250	4,250	OFFICE SUPI	7,700
4,255	4,255	POSTAGE	4,109
4,260	4,260	TELEPHONE	9,357
4,275	4,275	TRAINING &	10,359
4,276			
4,280	4,280	GENERAL TI	7,645
4,281	4,281	MEAL EXPEI	27
4,285	4,285	EDUCATION	3,471
4,289	4,289	MEETINGS E	48
4,290	4,290	HELP WANTI	8,146
4,291	4,291	PROMOTION	3,456
4,292	4,292	PUBLIC REL/	10,653
4,300	4,300	LICENSE & F	76,485
4,310	4,310	DUES & SUB	11,456
4,320	4,320	CONTRIBUTI	1,549
4,350	4,350	PROFESSION	10,957
4,355	4,355	MEDICAL DI	2,400
4,362			353
4,363			7,735
4,364	4,364	SOCIAL SER'	3,815
4,370	4,370	TV RENTAL	9,405
4,383	4,383	BACKGROUI	5,665
4,390	4,390	OTHER TAXI	0
4,400	4,400	PAYROLL T/	375,360
4,401	4,401	PAYROLL T/	11,418
4,410	4,410	GROUP INSU	251,429
4,420	4,420	LIABILITY II	58,038
4,430	4,430	WORKMAN'S	70,627
4,435	4,435	W/C-FIRST A	141
4,436	4,436	DRUG TESTI	2,501
4,450	4,450	MANAGEME	419,284
4,460	4,460	BAD DEBTS	137,284
4,461	4,461	BAD DEBTS	67,284
4,470	4,470	LOST ITEMS-	0
4,475	4,475	UNIFORM EX	3,399
4,486	4,486	M.I.S. Softwar	62,916
4,490	4,490	MISC EXPEN	769
4,496	4,496	MISC. M.I.S. I	7,309
4,510	4,510	REAL ESTAT	0
4,600	4,600	LEASED EQU	23,479
5,110	5,110	MAINTENAN	80,167
5,120	5,120	MAINTENAN	6,596
5,130	5,130	ELECTRIC	78,378
5,131	5,131	NATURAL G.	25,690
5,133	5,133	WATER & SE	40,887
5,134	5,134	TRASH COLI	16,417
5,140	5,140	PROP/PLANT	24,476
5,160	5,160	GENERAL RI	47,341
5,165	5,165	MAINTENAN	19,171
5,210	5,210	DIETARY W/	515,103
5,220	5,220	DIETARY PT	40,299
5,248	5,248	FOOD PURCI	344,894
5,250	5,250	SUPPLIES DI	4,449
5,260	5,260	REPLACEME	2,032
5,270	5,270	KITCHEN SU	11,112
5,295	5,295	MEAL INCOM	(236,078)
5,310	5,310	LAUNDRY W	84,670
5,340	5,340	LAUNDRY P	6,269
5,370	5,370	REPLACEME	13,375
5,380			0
5,390	5,390	SUPPLIES	7,586
5,410	5,410	HOUSEKEEP	145,662
5,440	5,440	HOUSEKEEP	13,804
5,480	5,480	SUPPLIES-CI	79,733
5,490	5,490	SUPPLIES-HO	341
6,020	6,020	RN WAGES	724,098
6,030	6,030	DON WAGES	73,358
6,035	6,035	ADON WAGI	60,851
6,040	6,040	RN PTO & RE	56,144
6,120	6,120	LPN WAGES	510,580
6,140	6,140	LPN PTO & R	46,396
6,220	6,220	AIDES WAGI	1,352,619
6,240	6,240	AIDES PTO &	89,267
6,245			0
6,246			
6,247			
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB WAG	115,504
6,275	6,275	REHAB PTO	8,872
6,290	6,290	NURSING SU	67,835
6,295	6,295	NURSING SU	137,654
6,390	6,390	REPLACEME	19,676
6,490	6,490	OTHER	2,215
7,280	7,280	DRUG PURCI	444,747
7,281	7,281	DRUG PURCI	577,377
7,380	7,380	LABORATOI	15,743
7,391	7,390	X-RAY SERV	30,797
7,393			
7,510	7,510	ACTIVITIES	66,829
7,540	7,540	ACTIVITIES	7,168
7,590	7,590	ACTIVITIES	5,697
7,620	7,620	PHYSICAL TI	381,247
7,660	7,660	P.T. SUPPLY	947
7,710	7,710	SOCIAL SER'	43,290
7,720	7,720	SOCIAL SER'	2,795
7,730	7,730	SOCIAL SER'	412
7,740	7,740	OCCUPATIOI	455,068
7,750			0
7,770	7,770	SPEECH THE	53,644
7,820	7,820	BEAUTICIAN	16,452
7,890			954
7,960			0
8,120	8,120	INTEREST	0
8,125			59,019
8,130	8,130	DEPRECIATI	0
8,150			0
9,510	9,510	INTEREST IN	(847)
9,520	9,520	MISC NON-O	0
9,530	4,220		0
	8,100		569,400
	9,702		0
	5,230		0
			(394,809)

Expenses Fixed Assets

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	14,157	14,157
IPA	21,967	21,967
medicare	5,756	5,756
		41,880

Heritage Manor Streator
HFS ID# 203902216001
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	(71,370)
Provider Assesment Fee - $6.07	Line 20, Col 3	(219,273)
		(290,643)
Provider Participation Fee	Line 42	290,643
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(1,022,124)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(46,540)
		(1,068,664)
Ancillary Service Centers	Line 39	1,068,664