



Facility Name & ID Number Heritage Health-Chillicothe

# 0048868 Report Period Beginning: 01/01/14 Ending: 12/31/14

**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	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	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,949	8,300	3,772	32,021	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,949	8,300	3,772	32,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.75%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

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

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 3,772

Medicare Intermediary WPS

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

Facility Name &amp; ID Number

Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending:

12/31/14

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	240,583	12,493		253,076		253,076	5,543	258,619		1
2	Food Purchase		208,895		208,895		208,895	66	208,961		2
3	Housekeeping	107,495	27,879		135,374		135,374		135,374		3
4	Laundry	40,089	10,837		50,926		50,926		50,926		4
5	Heat and Other Utilities			79,731	79,731		79,731	1,512	81,243		5
6	Maintenance	75,449	55,753	72,403	203,605		203,605	18,886	222,491		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	463,616	315,857	152,134	931,607		931,607	26,007	957,614		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,821,989	158,951	50,356	2,031,296		2,031,296	321	2,031,617		10
10a	Therapy		553,714	611,885	1,165,599	(582,868)	582,731		582,731		10a
11	Activities	82,036	6,932		88,968		88,968		88,968		11
12	Social Services	36,841		2,757	39,598		39,598		39,598		12
13	CNA Training		4,574		4,574		4,574	932	5,506		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,940,866	724,171	676,998	3,342,035	(582,868)	2,759,167	1,253	2,760,420		16
	<b>C. General Administration</b>										
17	Administrative	80,000			80,000		80,000		80,000		17
18	Directors Fees										18
19	Professional Services			291,376	291,376		291,376	(268,155)	23,221		19
20	Dues, Fees, Subscriptions & Promotions			146,707	146,707	(60,225)	86,482	(54,179)	32,303		20
21	Clerical & General Office Expenses	215,419	25,140	13,338	253,897		253,897	339,981	593,878		21
22	Employee Benefits & Payroll Taxes			522,301	522,301		522,301	55,957	578,258		22
23	Inservice Training & Education			7,600	7,600		7,600	1,661	9,261		23
24	Travel and Seminar			26,109	26,109		26,109	(21,110)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,616	62,616		62,616	12,526	75,142		26
27	Other (specify):* <b>Lost Resident Items</b>			57,386	57,386		57,386	(56,179)	1,207		27
28	<b>TOTAL General Administration</b>	295,419	25,140	1,127,433	1,447,992	(60,225)	1,387,767	10,502	1,398,269		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,699,901	1,065,168	1,956,565	5,721,634	(643,093)	5,078,541	37,762	5,116,303		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							239,156	239,156			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,941	22,941		22,941	109,818	132,759			32
33	Real Estate Taxes							73,594	73,594			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(474,811)	6,989			34
35	Rent-Equipment & Vehicles			9,864	9,864		9,864	8,842	18,706			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			514,605	514,605		514,605	(43,401)	471,204			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					582,868	582,868	(48,454)	534,414			39
40	Barber and Beauty Shops			6,437	6,437		6,437		6,437			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,225	60,225		60,225			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			6,437	6,437	643,093	649,530	(48,454)	601,076			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,699,901	1,065,168	2,477,607	6,242,676		6,242,676	(54,093)	6,188,583			45

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

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning: 01/01/14

Ending: 12/31/14

**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(22,439)			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	(2,675)			17
18	Fines and Penalties				18
19	Entertainment	(29,919)			19
20	Contributions	(1,179)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,080)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,000)			24
25	Fund Raising, Advertising and Promotional	(60,468)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (184,760)		\$	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	2	
		Amount	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)	130,667		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 130,667		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (54,093)		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	2	3	4
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Heritage Health-Chillicothe

ID# 0048868

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		(2,675)	20	17
18				18
19			24	19
20		(1,179)	27	20
21				21
22		(13,080)	19	22
23				23
24		(55,000)	27	24
25		(60,468)	20	25
26				26
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	<b>Total</b>		(132,402)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending:

12/31/14

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	5,543	0	0	0	0	0	0	0	0	5,543	1
2	Food Purchase	0	0	66	0	0	0	0	0	0	0	0	66	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,512	0	0	0	0	0	0	0	0	1,512	5
6	Maintenance	0	0	18,886	0	0	0	0	0	0	0	0	18,886	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>26,007</b>	<b>0</b>	<b>26,007</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	321	0	0	0	0	0	0	0	0	321	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	932	0	0	0	0	0	0	0	0	932	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>1,253</b>	<b>0</b>	<b>1,253</b>	<b>16</b>							
	<b>C. General Administration</b>													
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	(13,080)	(277,384)	22,309	0	0	0	0	0	0	0	0	(268,155)	19
20	Fees, Subscriptions & Promotions	(63,143)	0	8,964	0	0	0	0	0	0	0	0	(54,179)	20
21	Clerical & General Office Expenses	0	0	339,981	0	0	0	0	0	0	0	0	339,981	21
22	Employee Benefits & Payroll Taxes	0	0	55,957	0	0	0	0	0	0	0	0	55,957	22
23	Inservice Training & Education	0	0	1,661	0	0	0	0	0	0	0	0	1,661	23
24	Travel and Seminar	(29,919)	0	8,809	0	0	0	0	0	0	0	0	(21,110)	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	12,526	0	0	0	0	0	0	0	0	12,526	26
27	Other (specify):*	(56,179)	0	0	0	0	0	0	0	0	0	0	(56,179)	27
28	<b>TOTAL General Administration</b>	<b>(162,321)</b>	<b>(277,384)</b>	<b>450,207</b>	<b>0</b>	<b>10,502</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(162,321)</b>	<b>(277,384)</b>	<b>477,467</b>	<b>0</b>	<b>37,762</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14 Ending:

12/31/14

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	0	216,935	0	22,221	0	0	0	0	0	0	0	239,156	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,439)	132,285	0	(28)	0	0	0	0	0	0	0	109,818	32
33	Real Estate Taxes	0	73,594	0	0	0	0	0	0	0	0	0	73,594	33
34	Rent-Facility & Grounds	0	(481,800)	0	6,989	0	0	0	0	0	0	0	(474,811)	34
35	Rent-Equipment & Vehicles	0	0	0	8,842	0	0	0	0	0	0	0	8,842	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(22,439)</b>	<b>(58,986)</b>	<b>0</b>	<b>38,024</b>	<b>0</b>	<b>(43,401)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(48,454)	0	0	0	0	0	0	0	0	0	(48,454)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>(48,454)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(48,454)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(184,760)</b>	<b>(384,824)</b>	<b>477,467</b>	<b>38,024</b>	<b>0</b>	<b>(54,093)</b>	<b>45</b>						

**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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attachment-See Following Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt Scs</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</u>

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(48,454)</u>	<u>(48,454)</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>277,384</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(277,384)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>481,800</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(481,800)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>73,594</u>	<u>73,594</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>126,535</u>	<u>126,535</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>216,935</u>	<u>216,935</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,750</u>	<u>5,750</u>	10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		<b>\$ 759,184</b>			<b>\$ 374,360</b>	<b>\$ * (384,824)</b>	14

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$ 5,543	15
16	V	2 Food Purchase					66	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,512	19
20	V	6 Maintenance					18,886	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					321	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					932	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					22,309	31
32	V	20 Fees, Subscription, Promotions					8,964	32
33	V	21 Clerical & General Office Expenses					339,981	33
34	V	22 Employee Benefits & Payroll Taxes					55,957	34
35	V	23 Inservice Training & Education					1,661	35
36	V	24 Travel and Seminar					8,809	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					12,526	38
39	<b>Total</b>		\$			\$	0	\$ * 477,467 39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$	\$	0	15	
16	V	30 Depreciation						22,221	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(28)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						6,989	20	
21	V	35 Rent-Equipment & Vehicles						8,842	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	\$ *	38,024	39

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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Heritage Enterprises Inc.	Sole Member		100.00					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending: 12/31/14

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  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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,666	25	\$ 134,342	\$ 134,342	110	\$ 5,543	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	110	66	2
3	3	Housekeeping	Beds	2,666	25	0	0	110	0	3
4	4	Laundry	Beds	2,666	25	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	110	1,512	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	110	18,886	6
7	7	Other	Beds	2,666	25	0	0	110	0	7
8	9	Medical Director	Beds	2,666	25	0	0	110	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	110	321	9
10	11	Activities	Beds	2,666	25	0	0	110	0	10
11	12	Social Service	Beds	2,666	25	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	110	932	12
13	14	Program Transportation	Beds	2,666	25	0	0	110	0	13
14	15	Other	Beds	2,666	25	0	0	110	0	14
15	17	Administrative	Beds	2,666	25	0	0	110	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	110	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	110	22,309	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	110	8,964	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	110	339,981	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	110	55,957	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	110	1,661	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	110	8,809	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	110	12,526	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 477,467	25

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending: 12/31/14

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  NO

Name of Related Organization See PG 8  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,666	25	\$	\$	110	\$	1
2	30	Depreciation	Beds	2,666	25	538,548		110	22,221	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25			110		3
4	32	Interest	Beds	2,666	25	(682)		110	(28)	4
5	33	Real Estate Taxes	Beds	2,666	25			110		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393		110	6,989	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306		110	8,842	7
8	36	Other	Beds	2,666	25			110		8
9	38	Medically Nec Transportation	Beds	2,666	25			110		9
10	39	Ancillary Service Centers	Beds	2,666	25			110		10
11	40	Barber and Beauty Shops	Beds	2,666	25			110		11
12	41	Coffee and Gift Shops	Beds	2,666	25			110		12
13	42	Other	Beds	2,666	25			110		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					\$ 921,565	\$		\$ 38,024	25

Facility Name & ID Number

Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Busey Bank		x	Mortgage			\$	\$			\$ 126,535					
2	Busey Bank		x	Loan Fee Amortization							5,750					
3																
4																
5																
<b>Working Capital</b>																
6	Bank of America		x	Working Capital							22,941					
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 155,226					
<b>B. Non-Facility Related*</b>																
10	Interest Income										(22,439)					
11																
12	Allocated Corporate										(28)					
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (22,467)					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 132,759					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1.	Real Estate Tax accrual used on 2013 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.)	\$	73,594		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	73,594		3
4.	Real Estate Tax accrual used for 2014 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	73,594		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2009	_____	8	
		2010	_____	9	
		2011	74,372	10	
		2012	73,069	11	
		2013	73,594	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2013 \$		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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Chillicothe COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0048868

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>0529376016</u>	_____	\$ <u>72,390.42</u>	\$ <u>72,390.42</u>
2. <u>0529376017</u>	_____	\$ <u>1,203.96</u>	\$ <u>1,203.96</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>73,594.38</u></u>	\$ <u><u>73,594.38</u></u>

**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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868 Report Period Beginning:

01/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (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  (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  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				\$ <u>129,000</u>	1
2					2
3	TOTALS			\$ <u>129,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	110			\$ 3,301,403	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9	Awning		1998	2,334				
10	Heritage Sign		1998	1,860				
11	Chiller Replacement		1998	54,444				
12								
13	Interior Remodel--Materials		1999	154,576				
14			1999					
15	Interior Remodel--Professional Fees		1999	24,247				
16								
17	Water Heater controls		2000	1,347				
18	Water Heater		2000	57,254				
19	Door Locks		2000	1,997				
20	Heat / Cool Fan		2000	1,598				
21	Fire Alarm System		2000	4,400				
22	Alzheimer Unit -- Professional Fees		2000	25,115				
23	Interior Remodel--Materials (see attached)		2000	93,951				
24	Interior Remodel--Labor (see attached)		2000	23,130				
25	Interior Remodel--Professional Fees (see attached)		2000	5,762				
26								
27	Water Softener		2001	4,246				
28	Boiler		2001	29,350				
29	Door Holders		2001	654				
30	Alzheimer Unit -- Professional Fees		2001	4,660				
31								
32								
33	C/O Allocation				22,221		22,221	
34	Book Depreciation				186,783		186,783	
35								
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 &amp; ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpet	2002	\$ 2,373	\$		\$	\$	\$	37
38	Compressor	2002	1,164						38
39	Compressor	2002	7,234						39
40	Windows	2002	1,722						40
41									41
42	Storage Tank	2003	737						42
43	In-sink Aerator	2003	810						43
44	Boiler	2003	16,393						44
45	Carpet	2003	2,839						45
46									46
47	Smoke detectors	2004	2,285						47
48	Dinning Room Waitress	2004	2,617						48
49	Parking Lot Sealcoat	2004	4,926						49
50	Boiler Pipe	2004	3,775						50
51	Auto Trans Switch	2004	16,847						51
52	Day Room	2004	1,778						52
53									53
54	Day Room	2005	8,753						54
55	Boiler	2005	19,619						55
56	Fire Alarm	2005	1,628						56
57	Resident Room Carpet	2005	698						57
58	Security System	2005	6,393						58
59	Breaker Replacement	2005	1,980						59
60	Condenser	2005	1,118						60
61	Roof	2005	188,466						61
62	Wiring	2005	820						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,087,303	\$ 209,004		\$ 209,004	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,087,303	\$ 209,004		\$ 209,004	\$	\$	1
2	Heat pump	2006	5,669						2
3	Boiler	2006	72,981						3
4	fire Alarm	2006	3,553						4
5	Roof	2006	1,300						5
6	Kitchen remodel	2006	4,623						6
7	Carpet	2006	1,139						7
8	Condensing Unit	2006	2,000						8
9	East Wing Dinning Room Remodel	2006	5,228						9
10									10
11	East Wing Remodel-- paint, floors	2007	23,281						11
12	Boiler	2007							12
13	Fire Alarm	2007							13
14	Generator	2007							14
15	Code Alert	2007	4,622						15
16	Fence	2007	3,089						16
17	Landscapping	2007							17
18	Parking Lot sealer	2007	5,000						18
19	Generator	2007	8,260						19
20	Heat pump	2007	21,969						20
21	Water Line	2007							21
22									22
23	East Wing Remodel-- paint, floors	2008	61,290						23
24	Sprinkler Backflow	2008	4,360						24
25	Heat pump	2008	16,046						25
26	Soiled Utility/Med Room	2008	2,622						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,334,335	\$ 209,004		\$ 209,004	\$	\$	34

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

Facility Name &amp; ID Number Heritage Health-Chillicothe

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,334,335	\$ 209,004		\$ 209,004	\$	\$	1
2									2
3	Window replacements	2009	64,129						3
4									4
5	HVAC	2009	6,180						5
6	Heat Pump	2009	26,052						6
7	Nurse Call system	2009	226,889						7
8									8
9	Chiller	2010	3,429						9
10	Data Equipment Relocation	2010	2,658						10
11	Roof	2010	129,751						11
12	Paint, flooring & Labor Dining Room	2010	7,567						12
13									13
14	Sprinkler system	2011	77,240						14
15	Coil Unit	2011	3,744						15
16	Fluid cooler	2011	40,567						16
17	Exhaust fans	2011	7,141						17
18	Concrete walkway	2011	10,067						18
19	Remodel Administrator's office	2011	3,200						19
20	Sign	2011	19,723						20
21	Boiler	2011	13,577						21
22									22
23	Lighting Upgrade	2012	6,143						23
24	Boiler	2012	15,051						24
25									25
26	Boiler Replacement Final Payment	2013	3,132						26
27	Labor - Interior design of planned facility renovation	2013	12,052						27
28	Ceiling Replacement - Removal of old ceiling & asbestos	2013	46,400						28
29	Ceiling Replacement - Labor and materials to install new	2013	18,882						29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,077,909	\$ 209,004		\$ 209,004	\$	\$	34

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

Facility Name & ID Number Heritage Health-Chillicothe

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 5,077,909	\$ 209,004		\$ 209,004	\$	\$	1
2									2
3	Install Boiler Pump	2014	2,700						3
4	Install New Compresspr	2014	3,675						4
5	Install New Disposal	2014	2,634						5
6	Facility Renovation Project -	2014	797,218						6
7	54 Patient Rooms - New Flooring, Cabinetry, Furniture								7
8	(including beds); Painting and Wallcovering Removal;								8
9	New Flooring in all hallways and other common areas;								9
10	New Tables and Chairs in both dining areas; New Cabinets								10
11	and Flooring for both Nursing Stations; New Plumbing								11
12	Fixtures Throughout entire facility								12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,884,136	\$ 209,004		\$ 209,004	\$	\$	34

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

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	\$ 745,473	\$ 30,152	\$ 30,152	\$		\$	71
72	Current Year Purchases	101,547						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 847,020	\$ 30,152	\$ 30,152	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 6,860,156	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 239,156	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 239,156	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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: \$ 9,864 Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Heritage Health-Chillicothe # 0048868 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		4,574		4,574
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 4,574	\$	\$ 4,574
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,574		

**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**

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

- (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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 235,870	\$		\$ 235,870	1
2	Licensed Speech and Language Development Therapist		hrs				52,691			52,691	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				291,987	2,183		294,170	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					551,531		551,531	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						31,337			31,337	13
14	<b>TOTAL</b>			\$			\$ 611,885	\$ 553,714		\$ 1,165,599	14

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

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 14,450	\$	1
2	Cash-Patient Deposits	23,715		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,121,700		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,863		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(330,605)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 846,123	\$	10
<b>B. Long-Term Assets</b>				
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 846,123	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 259,562	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,715		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,815		30
31	Accrued Taxes Payable (excluding real estate taxes)	(24,011)		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Assessment Tax</u>	73,350		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 604,431	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 604,431	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 241,692	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 846,123	\$	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>12,255</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>12,255</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>229,437</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>229,437</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>241,692</b>	<b>24</b> *

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

**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.

		1		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 5,612,927	1	
2	Discounts and Allowances for all Levels	(2,225,719)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,387,208	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	2,040,555	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,040,555	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	(2,120)	12	
13	Barber and Beauty Care	5,987	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,012,878	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	5,166	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,021,911	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	22,439	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 22,439	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28			28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,472,113	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	931,607	31	
32	Health Care	3,342,035	32	
33	General Administration	1,447,992	33	
<b>B. Capital Expense</b>				
34	Ownership	514,605	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	6,437	35	
36	Provider Participation Fee		36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,242,676	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	229,437	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 229,437	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	49

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

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

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

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

Facility Name & ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,004	2,004	\$ 68,255	\$ 34.06	1
2	Assistant Director of Nursing	2,118	2,118	67,575	31.91	2
3	Registered Nurses	12,396	13,329	350,379	26.29	3
4	Licensed Practical Nurses	17,160	18,452	419,128	22.71	4
5	CNAs & Orderlies	61,706	66,349	817,344	12.32	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,925	5,296	99,308	18.75	8
9	Activity Director					9
10	Activity Assistants	6,610	7,108	82,036	11.54	10
11	Social Service Workers	1,947	2,094	36,841	17.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,835	21,328	240,583	11.28	15
16	Dishwashers					16
17	Maintenance Workers	3,522	3,787	75,449	19.92	17
18	Housekeepers	9,151	9,840	107,495	10.92	18
19	Laundry			40,089		19
20	Administrator	1,900	2,080	80,000	38.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,291	11,066	215,419	19.47	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)	153,565	164,851	\$ 2,699,901 *	\$ 16.38	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	3,269		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,600		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	2,757		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,626		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Heritage Health-Chillicothe

# 0048868

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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. \$ 60,225  
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. \$ 3,999
- (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 Line #	Sch 5 pg Col #	Sch 6 pg Line #	Adjustment Amount			
1009	PETTY CASH	14,450						1,009	1,009	PETTY CASH 14,450
1010	CASH IN BANK							1,100	1,100	ACCTS RECEIVABLE 1,121,700
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	1,121,700						1,110	1,110	ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES							1,125	1,125	ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE							1,135	1,135	ACCTS RECEIV-IC
1130	MEDICARE COST REPORT							1,140	1,140	UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC							1,145	1,145	A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS							1,200	1,200	PREPAID 16,863
1145	A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC							1,300	1,300	DIETARY INVENTORY
1200	PREPAID INSURANCE	16,863						1,310	1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY
1300	FOOD INVENTORY							1,409	1,409	LAND 0
1310	SUPPLIES INVENTORY							1,450	1,450	FURNITURE 0
1409	LAND	0						1,460		0
1450	FURNITURE & EQUIPMENT	0						1,475	1,475	CODE AL 0
1460	ACCUM DEPR-FURN & EQUIP	0						1,490	1,490	ACCUM DEPR 0
1475	BUILDING & IMPROVEMENTS	0						1,530	1,530	RESIDENT FUNDS 23,715
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FEES 0
1530	RESIDENT FUNDS	23,715						1,551	1,551	LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850	INTERCOMPANY (330,605)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUNTS PAYABLE (259,562)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
1850	INTRACOMPANY	-330,605						2,100	2,100	ACCRUED PAYROLL (143,378)
2010	ACCOUNTS PAYABLE	-259,562						2,100	2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-143,378						2,110	2,110	ACCRUED PAYROLL (128,437)
2110	ACCRUED VACATION PAY	-128,437						2,120	2,120	U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	24,011
2125	FICA TAX PAYABLE	24,011	24,011	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REFU	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETER	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GA	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUEI	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(73,350)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-73,350		2,400	2,400 CURRENT PORTION OF LT DEB	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(23,715)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	(12,255)
2460	INCOME TAXES PAYABLE				net income	(229,437)
2512	DUE TO RESIDENTS	-23,715				
2600	MORTGAGE PAYABLE	0				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-12,255				
2970	PROFIT/LOSS FOR PERIOD	-229,437				
3007.1	PATIENT DAYS-PRIVATE	8,300				3,007

3007.2	PATIENT DAYS-IPA	19,949						3,007
3007.3	PATIENT DAYS-MEDICARE	3,772						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE & VA	-5,603,628	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARE	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVATE	-8,581	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-1,012,878	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,040,555	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,225,719	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	-5,987		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-300		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	2,420		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-718		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-5,166		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	203,215	215,419	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	80,000	80,000	17	1	0	0		4,120
4115	VACATION & SICK - G&A	12,204		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	16,067	522,301	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP COST	-317		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255 OFFICE SUPPLIES	25,140	25,140	21	2	0	0		4,275
4260	TELEPHONE	13,338	13,338	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	7,600	7,600	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	20,814	26,109	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	715		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	4,580		24	3	19	-29,919 ***		4,289
4290	HELP WANTED ADVERTISING	14,626	146,707	20	3	0	0 -60,225		4,290
4291	PROMOTIONAL ADVERTISING	41,664		20	3	25	-41,664		4,291
4292	PUBLIC RELATIONS	18,804		20	3	25	-18,804		4,292
4300	LICENSES & FEES	61,907		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	8,049		20	3	17	-2,675		4,310
4320	CONTRIBUTIONS	1,179		27	3	20	-1,179		4,320
4350	PROFESSIONAL FEES	13,992	291,376	19	3	22	-13,080		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSULT	3,269		10	3	0	0	4,364
4363	PHARMACIST FEES	6,600		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	2,757	2,757	12	3	0	0	4,383
4370	TV RENTAL	5,861		35	3	5	0	4,390
4380	INCOME TAXES		57,386	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,657		20	3	26	0	4,401
4400	PAYROLL TAXES	246,753		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	8,304		22	3	0	0	4,420
4410	GROUP INSURANCE	198,801		22	3	0	0	4,430
4420	LIABILITY INSURANCE	62,616	62,616	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	52,693		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	277,384		19	3	34	0 **	4,460
4460	BAD DEBTS	55,000		27	3	24	-55,000	4,461
4470	LOST ITEMS-RESIDENTS	1,207		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	4,003	9,864	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	69,332	75,449	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	6,117		6	1	0	0	4,510
5130	ELECTRIC	41,117	79,731	5	3	0	0	4,600
5131	NATURAL GAS	24,077		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	14,537		5	3	0	0	5,130
5134	TRASH COLLECTION	16,431	72,403	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	18,912	55,753	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	36,841		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	55,972		6	3	0	0	5,140
5210	DIETARY WAGES	224,334	240,583	1	1	0	0	5,160
5220	DIETARY SICK & VAC	16,249		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	212,894	208,895	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,861	12,493	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	2,347		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,285		1	2	0	0	5,260
5295	MEAL CREDIT	-3,999		2	2	0	0	5,270
5310	LAUNDRY WAGES	37,587	40,089	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,502		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	5,272	10,837	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	5,565		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	100,790	107,495	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	6,705		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	23,209	27,879	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	4,670		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,821,989	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	320,335		10	1	0	0	6,020
6030	DON WAGES	68,255		10	1	0	0	6,030
6035	ADON	67,575		10	1	0	0	6,035
6040	RN SICK & VACATION	30,044		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	392,384		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	26,744		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	779,145		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	38,199		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	2,912		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	37,461		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	4,574	4,574	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	96,904		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,404		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	92,471	158,951	10	2	0	0	7,281
6295	NURSING SUPPLIES	66,081		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	399		10	2	0	0	7,391
6490	NURSING OTHER	114	50,356	10	3	0	0	7,393
7280	DRUG PURCHASES	231,846	553,714	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	319,685		39	2			7,540
7380	LABORATORY SERVICES	31,337	611,885	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	76,897	82,036	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,139		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	6,932	6,932	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	291,987		39	3	0	0 ***	7,890
7660	PT SUPPLIES	2,183		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	35,474	36,841	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	1,367		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	235,870		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	52,691		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	6,437	6,437	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	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	481,800	481,800	34	3	0	0	

8120	INTEREST EXPENSE	22,941	22,941	32	3	14	-22,439	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-22,439		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

6,220,237 6,242,676  
22,439

GRAND TOTALS

-229,437 -184,760  
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	8,300	8,300
IPA	19,949	19,949
medic	3,772	3,772
		32,021

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3,007 PATIENT

8,300

HFS 3745 (N-4-99)

IL478-2471

3,007 PATIENT	19,949
3,007 PATIENT	3,772
	0
3,010 BASIC CI	(5,603,628)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(8,581)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(1,012,878)
	0
3,110 PHYSICIAN	(2,040,555)
	0
3,112 PHYSICIAN	0
3,113 PHYSICIAN	0
3,140 LABORATORY INCOME	0
	0
3,152 ST/OT TR	0
3,153 ST/OT TR	0
3,185 REHABILITATION/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	2,148,712

3,520 RENT INC	0
3,530 BEAUTY	(5,987)
	(300)
3,570 VENDING	2,420
3,590 EQUIPMI	(718)
3,595 RESIDEN	(5,166)
3,600 MISC INC	0
4,110 G&A WA	203,215
4,111 ADMINIS	80,000
4,115 G&A PTC	12,204
4,120 EMPLOY	16,349
4,130 EMPLOY	0
4,135 EMPLOY	(317)
4,250 OFFICE S	11,575
4,255 POSTAGI	1,496
4,260 TELEPHC	13,338
4,275 TRAININ	7,600
	0
4,280 GENERA	20,814
4,281 MEAL EX	715
4,285 EDUCAT	2,631
4,289 MEETING	1,949
4,290 HELP WA	14,626
4,291 PROMOT	41,664
4,292 PUBLIC I	18,804
4,300 LICENSE	61,907
4,310 DUES & S	8,049
4,320 CONTRIE	1,179
4,350 PROFESS	13,992
4,355 MEDICAL	12,000
	3,269
	6,600

4,364 SOCIAL S	2,757
4,370 TV RENT	5,861
4,383 BACKGR	1,657
4,390 OTHER T	0
4,400 PAYROL	246,753
4,401 PAYROL	8,304
4,410 GROUP I	198,801
4,420 LIABILIT	62,616
4,430 WORKM	50,685
4,435 W/C-FIRS	0
4,436 DRUG TE	2,008
4,450 MANAGI	277,384
4,460 BAD DEF	55,000
4,461 BAD DEF	77,007
4,470 LOST ITE	1,207
4,475 UNIFORM	(282)
4,486 SERVICE	23,504
4,490 MISC EX	128
4,496 MISC. M.	12,069
4,510 REAL ES	0
4,600 LEASED	4,003
5,110 MAINTEI	69,332
5,120 MAINTEI	6,117
5,130 ELECTRI	41,117
5,131 NATURA	24,077
5,133 WATER &	14,537
5,134 TRASH C	16,431
5,140 PROP/PL	18,912
5,160 GENERA	36,841
5,165 MAINTEI	32,468
5,210 DIETARY	224,334
5,220 DIETARY	16,249
5,248 FOOD PU	212,766

5,250 SUPPLIE	2,861
5,260 REPLACI	2,347
5,270 KITCHEN	7,285
5,295 MEAL IN	(3,999)
5,310 LAUNDR	37,587
5,340 LAUNDR	2,502
5,370 REPLACI	5,272
	0
5,390 SUPPLIE	5,565
5,410 HOUSEK	100,790
5,440 HOUSEK	6,705
5,480 SUPPLIE	23,209
5,490 SUPPLIE	4,670
6,020 RN WAG	320,335
6,030 DON WA	68,255
6,035 ADON W	67,575
6,040 RN PTO &	30,044
6,120 LPN WAG	392,384
6,140 LPN PTO	26,744
6,220 AIDES W	779,145
6,240 AIDES PT	38,199
6,245	0
	2,912
	37,461
	0
	4,574
	0
6,270 REHAB V	96,904
6,275 REHAB F	2,404
6,290 NURSINC	92,471
6,295 NURSINC	66,081
6,390 REPLACI	399
6,490 OTHER	114

7,280 DRUG PU	231,846
7,281 DRUG PU	319,685
7,380 LABORA	16,464
7,390 X-RAY S	14,873
	0
7,510 ACTIVIT	76,897
7,540 ACTIVIT	5,139
7,590 ACTIVIT	6,932
7,620 PHYSICA	291,987
7,660 P.T. SUPE	2,183
7,710 SOCIAL S	35,474
7,720 SOCIAL S	1,367
7,730 SOCIAL S	0
7,740 OCCUPA	235,870
7,770 SPEECH '	52,691
7,820 BEAUTIC	6,437
	0
	0
8,120 INTERES	0
	22,941
8,130 DEPRECI	0
	0
9,510 INTERES	(22,439)
9,520 MISC NO	0
4,220	0
8,100	481,800
9,702	0
5,230	0
	<u>(229,437)</u>

Expenses Fixed Assets

