

		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: 0048843

Facility Name: Heritage Health Beardstown

Address: 8306 St Lukes Drive Beardstown 62618
Number City Zip Code

County: Cass

Telephone Number: (217) 323-4055 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid
Preparer

(Signed)
(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 Beardstown

0048843 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	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	79	Skilled (SNF)	79	28,914	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	79	TOTALS	79	28,914	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,780	7,721	2,454	23,955	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,780	7,721	2,454	23,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.85%

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 7/2006

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 2,454

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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 & ID Number Heritage Health Beardstown # 0048843 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 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	
	A. General Services											
1	Dietary	223,517	9,258		232,775		232,775	4,133	236,908			1
2	Food Purchase		212,850		212,850		212,850	(118,929)	93,921			2
3	Housekeeping	86,074	23,191		109,265		109,265	(45,173)	64,092			3
4	Laundry	54,744	6,334		61,078		61,078		61,078			4
5	Heat and Other Utilities			239,334	239,334		239,334	1,284	240,618			5
6	Maintenance	98,404	52,520	59,617	210,541		210,541	(75,410)	135,131			6
7	Other (specify):*											7
8	TOTAL General Services	462,739	304,153	298,951	1,065,843		1,065,843	(234,095)	831,748			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,330,507	98,750	17,716	1,446,973		1,446,973	(11,252)	1,435,721			10
10a	Therapy		502,186	28,305	530,491	(529,776)	715		715			10a
11	Activities	49,169	3,951		53,120		53,120		53,120			11
12	Social Services	32,277		3,857	36,134		36,134		36,134			12
13	CNA Training							1,018	1,018			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,411,953	604,887	52,878	2,069,718	(529,776)	1,539,942	(10,234)	1,529,708			16
	C. General Administration											
17	Administrative	76,500			76,500		76,500		76,500			17
18	Directors Fees											18
19	Professional Services			260,329	260,329		260,329	(241,796)	18,533			19
20	Dues, Fees, Subscriptions & Promotions			226,955	226,955	(167,211)	59,744	(6,809)	52,935			20
21	Clerical & General Office Expenses	143,626	16,551	20,429	180,606		180,606	132,939	313,545			21
22	Employee Benefits & Payroll Taxes			391,321	391,321		391,321	32,568	423,889			22
23	Inservice Training & Education			7,135	7,135		7,135	998	8,133			23
24	Travel and Seminar			3,494	3,494		3,494	1,505	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,773	41,773		41,773	13,662	55,435			26
27	Other (specify):* Lost resident credit			79,395	79,395		79,395	(79,680)	(285)			27
28	TOTAL General Administration	220,126	16,551	1,030,831	1,267,508	(167,211)	1,100,297	(146,613)	953,684			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,094,818	925,591	1,382,660	4,403,069	(696,987)	3,706,082	(390,942)	3,315,140			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							187,941	187,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,871	35,871		35,871	56,888	92,759			32
33	Real Estate Taxes							45,342	45,342			33
34	Rent-Facility & Grounds			459,900	459,900		459,900	(516,934)	(57,034)			34
35	Rent-Equipment & Vehicles			18,311	18,311		18,311	7,355	25,666			35
36	Other (specify):*											36
37	TOTAL Ownership			514,082	514,082		514,082	(219,408)	294,674			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			447,518	447,518	529,776	977,294	(91,132)	886,162			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					167,211	167,211		167,211			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			447,518	447,518	696,987	1,144,505	(91,132)	1,053,373			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,094,818	925,591	2,344,260	5,364,669		5,364,669	(701,482)	4,663,187			45

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

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	(61,914)			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	(179)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,650)			19
20	Contributions	(507)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,192)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,173)			24
25	Fund Raising, Advertising and Promotional	(14,696)			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)	\$ (165,311)		\$	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)	(536,171)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (536,171)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (701,482)		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

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		(507)	27	20
21				21
22		(5,192)	19	22
23				23
24		(79,173)	27	24
25		(14,696)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(99,568)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Beardstown

0048843

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,133	0	0	0	0	0	0	0	0	4,133	1
2	Food Purchase	0	(118,929)	0	0	0	0	0	0	0	0	0	(118,929)	2
3	Housekeeping	0	(45,203)	30	0	0	0	0	0	0	0	0	(45,173)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,284	0	0	0	0	0	0	0	0	1,284	5
6	Maintenance	0	(92,701)	17,291	0	0	0	0	0	0	0	0	(75,410)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	(256,833)	22,738	0	0	0	0	0	0	0	0	(234,095)	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	(11,506)	254	0	0	0	0	0	0	0	0	(11,252)	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	1,018	0	0	0	0	0	0	0	0	1,018	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	(11,506)	1,272	0	0	0	0	0	0	0	0	(10,234)	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	(5,192)	(252,448)	15,844	0	0	0	0	0	0	0	0	(241,796)	19
20	Fees, Subscriptions & Promotions	(14,696)	0	7,887	0	0	0	0	0	0	0	0	(6,809)	20
21	Clerical & General Office Expenses	0	(108,382)	241,321	0	0	0	0	0	0	0	0	132,939	21
22	Employee Benefits & Payroll Taxes	0	0	32,568	0	0	0	0	0	0	0	0	32,568	22
23	Inservice Training & Education	0	0	998	0	0	0	0	0	0	0	0	998	23
24	Travel and Seminar	(3,650)	0	5,155	0	0	0	0	0	0	0	0	1,505	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	13,662	0	0	0	0	0	0	0	0	13,662	26
27	Other (specify):*	(79,680)	0	0	0	0	0	0	0	0	0	0	(79,680)	27
28	TOTAL General Administration	(103,218)	(360,830)	317,435	0	0	0	0	0	0	0	0	(146,613)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(103,218)	(629,169)	341,445	0	0	0	0	0	0	0	0	(390,942)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Beardstown # 0048843 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	165,472	0	22,469	0	0	0	0	0	0	0	187,941	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(179)	56,826	0	241	0	0	0	0	0	0	0	56,888	32
33	Real Estate Taxes	0	45,342	0	0	0	0	0	0	0	0	0	45,342	33
34	Rent-Facility & Grounds	(61,914)	(459,900)	0	4,880	0	0	0	0	0	0	0	(516,934)	34
35	Rent-Equipment & Vehicles	0	0	0	7,355	0	0	0	0	0	0	0	7,355	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(62,093)	(192,260)	0	34,945	0	0	0	0	0	0	0	(219,408)	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	(91,132)	0	0	0	0	0	0	0	0	0	(91,132)	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	(91,132)	0	0	0	0	0	0	0	0	0	(91,132)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(165,311)	(912,561)	341,445	34,945	0	0	0	0	0	0	0	(701,482)	45

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
				Evergreen Place	Beardstown	SLF

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	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy	0.00%	\$ (11,506)	\$ (11,506)	1
2	V	39	Adjustment for Related Organization		GreenTree Pharmacy		(91,132)	(91,132)	2
3	V	19	Adjustment for Related Organization	252,448	Heritage Operations Group, LLC	0.00%		(252,448)	3
4	V	34	Adjustment for Related Organization	459,900	Heritage Manor Real Estate, LLC	0.00%		(459,900)	4
5	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		45,342	45,342	5
6	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		54,146	54,146	6
7	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		165,472	165,472	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,680	2,680	8
9	V	21	Adjustment for Related Organization		Evergreen Place	0.00%	(108,382)	(108,382)	9
10	V	6	Adjustment for Related Organization		Evergreen Place		(92,701)	(92,701)	10
11	V	2	Adjustment for Related Organization		Evergreen Place		(118,929)	(118,929)	11
12	V	3	Adjustment for Related Organization		Evergreen Place		(45,203)	(45,203)	12
13	V								13
14	Total			\$ 712,348			\$ (200,213)	\$ * (912,561)	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 Operations Group LLC		\$	\$ 4,133	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					30	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,284	19
20	V	6	Maintenance					17,291	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					254	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,018	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					15,844	31
32	V	20	Fees, Subscription, Promotions					7,887	32
33	V	21	Clerical & General Office Expenses					241,321	33
34	V	22	Employee Benefits & Payroll Taxes					32,568	34
35	V	23	Inservice Training & Education					998	35
36	V	24	Travel and Seminar					5,155	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					13,662	38
39	Total			\$			\$ 0	\$ * 341,445	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 Operations Group LLC		\$	0	15
16	V	30	Depreciation					22,469	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					241	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,880	20
21	V	35	Rent-Equipment & Vehicles					7,355	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	\$ * 34,945	39

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

Facility Name & ID Number Heritage Health Beardstown # 0048843 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 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 Beardstown# 0048843

Report Period Beginning:

01/01/16Ending: 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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	79	\$ 4,133	1
2	2	Food Purchase	Beds	2,571	26	0	0	79	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	79	30	3
4	4	Laundry	Beds	2,571	26	0	0	79	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	79	1,284	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	79	17,291	6
7	7	Other	Beds	2,571	26	0	0	79	0	7
8	9	Medical Director	Beds	2,571	26	0	0	79	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	79	254	9
10	11	Activities	Beds	2,571	26	0	0	79	0	10
11	12	Social Service	Beds	2,571	26	0	0	79	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	79	1,018	12
13	14	Program Transportation	Beds	2,571	26	0	0	79	0	13
14	15	Other	Beds	2,571	26	0	0	79	0	14
15	17	Administrative	Beds	2,571	26	0	0	79	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	79	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	79	15,844	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	79	7,887	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	79	241,321	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	79	32,568	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	79	998	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	79	5,155	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	79	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	79	13,662	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 341,445	25

Facility Name & ID Number Heritage Health Beardstown # 0048843 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 ☒ 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	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	2,571	26	\$	\$	79	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		79	22,469	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			79		3
4	32	Interest	Beds	2,571	26	7,851		79	241	4
5	33	Real Estate Taxes	Beds	2,571	26			79		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		79	4,880	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		79	7,355	7
8	36	Other	Beds	2,571	26			79		8
9	38	Medically Nec Transportation	Beds	2,571	26			79		9
10	39	Ancillary Service Centers	Beds	2,571	26			79		10
11	40	Barber and Beauty Shops	Beds	2,571	26			79		11
12	41	Coffee and Gift Shops	Beds	2,571	26			79		12
13	42	Other	Beds	2,571	26			79		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	\$		\$ 34,945	25

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				\$					\$ 54,146	1
2	Bank of America		x									2,680	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x									35,871	6
7													7
8													8
9	TOTAL Facility Related						\$				\$ 92,697	9	
	B. Non-Facility Related*												
10	Interest Income											(179)	10
11													11
12	Allocated Corporate											241	12
13													13
14	TOTAL Non-Facility Related						\$				\$ 62	14	
15	TOTALS (line 9+line14)						\$				\$ 92,759	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.)

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.)				\$45,342	2
3. Under or (over) accrual (line 2 minus line 1).				\$45,342	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.				\$45,342	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	40,275	8	
		2012	40,926	9	
		2013	42,085	10	
		2014	43,776	11	
		2015	45,342	12	
				13	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.

FACILITY NAME	Heritage Health Beardstown	COUNTY	Cass
---------------	----------------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

A. Square Feet: 34,200

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).
Evergreen Place SLF - 26 Apartments - Related organization

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				\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	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	Adjustments	Accumulated Depreciation
4	79				\$ 1,380,636	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Remodel facilitiy--Materials & Labor			1997	272,458					9
10										10
11	Nurse Call System			1997	1,500					11
12										12
13	Remodel facilitiy--Materials & Labor			1998	85,772					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	Door Alarm System			2000	2,727					27
28	A/C Compressor			2000	2,984					28
29	Compressor -- Walk-in Freezer			2000	2,586					29
30	Water Heater			2000	2,804					30
31										31
32										32
33	C/O Allocation					22,469		22,469		33
34	Book Depreciation Excl SLF					143,504		143,504		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 Beardstown

0048843

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	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 Recirculating Pump	2001	\$ 889	\$		\$	\$	\$	37
38 West entrance Door	2001	1,700						38
39								39
40 Door	2002	2,840						40
41 a/c unit	2002	15,900						41
42 Shower room Wall	2002	1,200						42
43 Cmpressor	2002	13,348						43
44								44
45 Sewer Relocation	2002	2,011						45
46								46
47 Sewer Relocation	2003	2,206						47
48 a/c units	2003	10,170						48
49								49
50 Disposer	2003	1,454						50
51 A/C Unit	2003	5,786						51
52 Rebuild Generator	2003	4,276						52
53								53
54 Exterior doors	2004	3,212						54
55 Shower room Remodel	2004	9,028						55
56 Landscapping	2004	3,030						56
57 Canopy	2004	570						57
58 Door	2004	1,068						58
59 A/C Unit	2004	7,326						59
60 Heat/Cool Units	2004	6,960						60
61 Carpet	2004	911						61
62 Compressor	2004	2,949						62
63 Chiller	2004	1,970						63
64 Drier Core	2004	953						64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,851,224	\$ 165,973		\$ 165,973	\$	\$	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	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		\$ 1,851,224	\$ 165,973		\$ 165,973	\$	\$	1
2 Shower Remodel	2005	7,273						2
3 Ansul System	2005	2,540						3
4								4
5								5
6 Interior rehab -- Labor and Materials	2005	28,299						6
7 Delayed Egress Magnet	2005	2,092						7
8 Panic Door Hardware	2005	2,125						8
9 Roof repair	2005	3,702						9
10								10
11								11
12 Door opener	2006	2,445						12
13 Wanderguard system	2006	2,267						13
14 Hot water heater	2006	13,771						14
15 Sidewalk	2006	4,928						15
16								16
17 Hvac	2006	17,853						17
18								18
19 Alarm system	2006	6,568						19
20 Gererator regulator	2006	1,727						20
21 Awning	2006	4,264						21
22 Closet door	2006	2,722						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)		\$ 1,953,800	\$ 165,973		\$ 165,973	\$	\$	34

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

Facility Name & ID Number Heritage Health Beardstown

0048843

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	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 12B, Carried Forward		\$ 1,953,800	\$ 165,973		\$ 165,973	\$	\$	1
2	<u>HVAC</u>	2007	9,672						2
3	<u>Chiller</u>	2007	2,603						3
4									4
5	Post 6/30/07 capital review								5
6	<u>Landscaping</u>	2007	28,000						6
7	<u>Water Heater</u>	2007	21,682						7
8	<u>Rooftop A/C</u>	2007	205						8
9	<u>Blinds</u>	2007	845						9
10	<u>Roof fans</u>	2007	3,457						10
11	<u>A/C</u>	2007	12,487						11
12	<u>Doors</u>	2007	3,358						12
13	<u>Generator</u>	2007	39,004						13
14	<u>Wall Heater</u>	2007	3,384						14
15	<u>Circulating pump</u>	2007	896						15
16	<u>Roof</u>	2007	141,801						16
17	<u>Capital report Adj</u>	2007	(216,315)						17
18	<u>HVAC Rooftop Unit</u>	2008	148,000						18
19	<u>Water Heater</u>	2008	14,252						19
20	<u>Heater Replacement</u>	2008	4,008						20
21	<u>Resident Room Remodel-- Painting, Lighting</u>	2008	75,015						21
22	<u>Hot Water Heater</u>	2008	6,621						22
23	<u>HVAC Units</u>	2008	19,280						23
24	<u>Electric Heater</u>	2008	5,195						24
25	<u>Capital report Adj</u>	2008	(50,625)						25
26	<u>Elevator</u>	2009	9,873						26
27	<u>Mixing valve</u>	2009	3,715						27
28	<u>Room painting</u>	2009	6,065						28
29	<u>Comdensor</u>	2009	5,260						29
30	<u>Lights</u>	2009	4,055						30
31	<u>Parking Lot</u>	2009	83,790						31
32	<u>Flooring</u>	2009	18,770						32
33	<u>Nurse Call System</u>	2009	107,659						33
34	TOTAL (lines 1 thru 33)		\$ 2,465,812	\$ 165,973		\$ 165,973	\$	\$	34

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

Facility Name & ID Number Heritage Health Beardstown

0048843

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	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 12C, Carried Forward		\$ 2,465,812	\$ 165,973		\$ 165,973	\$	\$	1
2 Capital Report Adj	2009	(16,907)						2
3 Electric reheats	2010	2,953						3
4 HVAC units	2010	15,119						4
5 Insulation	2010	34,950						5
6 Parking Lot	2010	23,462						6
7 Nurse Call System	2010	183,517						7
8								8
9 Sprinkler	2011	83,201						9
10 Roof	2011	133,678						10
11 Heat/cool Units	2011	19,980						11
12 water tank	2011	7,503						12
13 Heat Panel	2011	5,003						13
14 sign	2011	14,000						14
15								15
16 Roof Replacement	2012	19,770						16
17 Water Heater	2012	13,243						17
18								18
19 Lighting	2012	22,130						19
20								20
21 Compressor Replacements	2013	10,494						21
22 Elevator Door Restrictor	2013							22
23 Replace Heat Controls	2013	4,940						23
24 Sprinkler System Installation	2013							24
25 Duct Heater Replacement	2013							25
26								26
27 Elevator Door Restrictor-Final Payment	2014							27
28 Replace Dishwasher	2014							28
29 Roof Replacement	2014	173,569						29
30 Rebuild Fan Motor	2014							30
31 Chiller Replacement	2014							31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,216,417	\$ 165,973		\$ 165,973	\$	\$	34

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

Facility Name & ID Number Heritage Health Beardstown

0048843

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 12D, Carried Forward		\$ 3,216,417	\$ 165,973		\$ 165,973	\$	\$	1
2									2
3	Supply and install 1200 amp breaker switch	2015	22,500						3
4	Install (8) PTAC units	2015	10,026						4
5	Replace duct heaters and controls	2015	2,537						5
6	Install new water tank	2015	4,805						6
7	Repalce water heater	2015	8,740						7
8									8
9	Installed (2) PTAC units in resident rooms	2016	4,146						9
10									10
11									11
12									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	TOTAL (lines 1 thru 33)		\$ 3,269,171	\$ 165,973		\$ 165,973	\$	\$	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	\$1,034,265	\$21,968	\$21,968	\$		\$	71
72	Current Year Purchases	12,812						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,047,077	\$21,968	\$21,968	\$		\$	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)	\$4,341,248	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$187,941	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$187,941	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

		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:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$18,311Description:Office equipment and mattresses
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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)	\$			

- (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.
- 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	
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 165,145	\$		\$ 165,145	1
2	Licensed Speech and Language Development Therapist		hrs			114,147			114,147	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			168,226	715		168,941	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				501,471		501,471	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					28,305			28,305	13
14	TOTAL			\$		\$ 475,823	\$ 502,186		\$ 978,009	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.

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	\$ 10,007	\$	1
2	Cash-Patient Deposits	15,648		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,296,547		3
4	Supply Inventory (priced at)	26,373		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,164		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,233,107)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 140,632	\$	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)	\$ 140,632	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 165,694	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,648		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	176,480		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,286		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	<u>Bed Tax</u>	23,669		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 385,777	\$	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)	\$ 385,777	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (245,145)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 140,632	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (690,572)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (690,572)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	445,427	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)	\$ 445,427	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)	\$ (245,145)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Beardstown

0048843

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,487,395	1
2	Discounts and Allowances for all Levels	(1,866,468)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,620,927	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,569,057	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,569,057	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	754	12
13	Barber and Beauty Care	730	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	61,914	16
17	Sale of Drugs	965,844	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	21,747	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,050,989	23
	D. Non-Operating Revenue		
24	Contributions	568,944	24
25	Interest and Other Investment Income***	179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 569,123	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,810,096	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,065,843	31
32	Health Care	2,069,718	32
33	General Administration	1,267,508	33
	B. Capital Expense		
34	Ownership	514,082	34
	C. Ancillary Expense		
35	Special Cost Centers	447,518	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,364,669	40
41	Income before Income Taxes (line 30 minus line 40)**	445,427	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 445,427	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.

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	1,832	1,928	\$ 54,191	\$ 28.11	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,843	5,098	149,125	29.25	3
4	Licensed Practical Nurses	17,245	18,153	425,832	23.46	4
5	CNAs & Orderlies	52,407	55,165	648,841	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,897	1,997	52,518	26.30	8
9	Activity Director					9
10	Activity Assistants	2,982	3,139	49,169	15.66	10
11	Social Service Workers	1,824	1,920	32,277	16.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,578	19,556	223,517	11.43	15
16	Dishwashers					16
17	Maintenance Workers	5,159	5,430	98,404	18.12	17
18	Housekeepers	7,099	7,473	86,074	11.52	18
19	Laundry	3,644	3,836	54,744	14.27	19
20	Administrator	1,984	2,088	76,500	36.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,517	8,965	143,626	16.02	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)	128,011	134,748	\$ 2,094,818 *	\$ 15.55	34

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		3,000		36
37	Medical Records Consultant		1,560		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,163		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		3,857		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,580		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		11,728		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		\$ 11,728		53

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

** See instructions.

Facility Name & ID Number		Heritage Health Beardstown		STATE OF ILLINOIS		# 0048843		Report Period Beginning:		01/01/16		Page 21		Ending:		12/31/16			
XIX. SUPPORT SCHEDULES																			
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions											
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount					
Lori Moon						\$ 76,500		Workers' Compensation Insurance		\$ 23,025		IDPH License Fee		\$					
								Unemployment Compensation Insurance		35,908		Advertising: Employee Recruitment		3,089					
								FICA Taxes		160,254		Health Care Worker Background Check							
								Employee Health Insurance		148,127		(Indicate # of checks performed)		1,553					
								Employee Meals											
								Illinois Municipal Retirement Fund (IMRF)*											
												PR		4,767					
TOTAL (agree to Schedule V, line 17, col. 1)								Other Benefits		24,007		Dues & Subscriptions		10,168					
(List each licensed administrator separately.)						\$ 76,500		Central Office Allocation		32,568		License & Fees		32,141					
B. Administrative - Other												Central Office Allocation				7,887			
Description						Amount						Less: Public Relations Expense		(4,767)					
						\$						Non-allowable advertising		(1,903)					
												Yellow page advertising		()					
TOTAL (agree to Schedule V, line 17, col. 3)						\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 423,889		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 52,935					
(Attach a copy of any management service agreement)																			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**											
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount			
Heritage Operations Group		Mgt services				\$ 252,448						\$		Out-of-State Travel		\$			
ADP		Payroll tax processing				1,234													
Tango Inc.		ACA compliance				625													
McKee Environmental		Inspections				830								In-State Travel					
																2,908			
																37			
														Seminar Expense		549			
																1,505			
Legal adj to Zero						5,192													
														Entertainment Expense		()			
TOTAL (agree to Schedule V, line 19, column 3)						\$ 260,329		TOTAL		\$				(agree to Sch. V, line 24, col. 8)					
(For legal fee disclosure, see page 39 of instructions)												TOTAL				\$ 4,999			
* Attach copy of IMRF notifications																			
**See instructions.																			

Facility Name & ID Number <u>Heritage Health Beardstown</u>	STATE OF ILLINOIS # <u>0048843</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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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. \$ 167,211
 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? Yes 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,822

(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

Heritage Manor Beardstown South
HFS ID# 205300302001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>		
Provider Participation Fee - \$1.50	Line 20, Col 3	(43,371)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(123,840)
		<u>(167,211)</u>
		<u>(167,211)</u>
Provider Participation Fee	Line 42	<u>167,211</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(501,471)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(28,305)
		<u>(529,776)</u>
		<u>(529,776)</u>
Ancillary Service Centers	Line 39	<u>529,776</u>