

Facility Name & ID Number Heritage Health Carlinville

0048850 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/25/16

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>95</u>	<u>35,862</u>	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	<u>108</u>	TOTALS	<u>95</u>	<u>35,862</u>	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	<u>14,269</u>	<u>13,366</u>	<u>2,927</u>	<u>30,562</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,269</u>	<u>13,366</u>	<u>2,927</u>	<u>30,562</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.22%

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 2,927

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 Carlinville # 0048850 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	199,871	10,344		210,215		210,215	4,970	215,185			1
2	Food Purchase		202,083		202,083		202,083		202,083			2
3	Housekeeping	111,153	30,809		141,962		141,962	36	141,998			3
4	Laundry	65,752	15,748		81,500		81,500		81,500			4
5	Heat and Other Utilities			118,368	118,368		118,368	1,544	119,912			5
6	Maintenance	65,714	52,096	64,191	182,001		182,001	20,793	202,794			6
7	Other (specify):*											7
8	TOTAL General Services	442,490	311,080	182,559	936,129		936,129	27,343	963,472			8
	B. Health Care and Programs											
9	Medical Director			14,500	14,500		14,500		14,500			9
10	Nursing and Medical Records	1,425,953	82,546	6,150	1,514,649		1,514,649	(16,241)	1,498,408			10
10a	Therapy		375,940	9,174	385,114	(384,582)	532		532			10a
11	Activities	75,719	1,541		77,260		77,260		77,260			11
12	Social Services	35,934		4,028	39,962		39,962		39,962			12
13	CNA Training							1,224	1,224			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,537,606	460,027	33,852	2,031,485	(384,582)	1,646,903	(15,017)	1,631,886			16
	C. General Administration											
17	Administrative	68,850			68,850		68,850		68,850			17
18	Directors Fees											18
19	Professional Services			267,251	267,251		267,251	(242,476)	24,775			19
20	Dues, Fees, Subscriptions & Promotions			246,396	246,396	(218,824)	27,572	1,721	29,293			20
21	Clerical & General Office Expenses	154,085	14,426	12,815	181,326		181,326	290,197	471,523			21
22	Employee Benefits & Payroll Taxes			416,057	416,057		416,057	39,164	455,221			22
23	Inservice Training & Education			5,890	5,890		5,890	1,200	7,090			23
24	Travel and Seminar			3,671	3,671		3,671	1,328	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,150	54,150		54,150	16,429	70,579			26
27	Other (specify):*			90,736	90,736		90,736	(90,736)				27
28	TOTAL General Administration	222,935	14,426	1,096,966	1,334,327	(218,824)	1,115,503	16,827	1,132,330			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,203,031	785,533	1,313,377	4,301,941	(603,406)	3,698,535	29,153	3,727,688			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							190,738	190,738			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,828	44,828		44,828	29,706	74,534			32
33	Real Estate Taxes							34,678	34,678			33
34	Rent-Facility & Grounds			473,040	473,040		473,040	(467,171)	5,869			34
35	Rent-Equipment & Vehicles			6,381	6,381		6,381	8,845	15,226			35
36	Other (specify):*											36
37	TOTAL Ownership			524,249	524,249		524,249	(203,204)	321,045			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			593,188	593,188	384,582	977,770	(71,956)	905,814			39
40	Barber and Beauty Shops			297	297		297		297			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					218,824	218,824		218,824			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			593,485	593,485	603,406	1,196,891	(71,956)	1,124,935			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,203,031	785,533	2,431,111	5,419,675		5,419,675	(246,007)	5,173,668			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				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	(129)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,871)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,211)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,736)			24
25	Fund Raising, Advertising and Promotional	(7,764)			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)	\$ (113,711)		\$	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)	(132,296)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (132,296)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (246,007)		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		0	27	20
21				21
22		(10,211)	19	22
23				23
24		(90,736)	27	24
25		(7,764)	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	(108,711)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Carlinville # 0048850 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	4,970	0	0	0	0	0	0	0	0	4,970	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	36	0	0	0	0	0	0	0	0	36	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,544	0	0	0	0	0	0	0	0	1,544	5
6	Maintenance	0	0	20,793	0	0	0	0	0	0	0	0	20,793	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,343	0	0	0	0	0	0	0	0	27,343	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	(16,546)	305	0	0	0	0	0	0	0	0	(16,241)	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	1,224	0	0	0	0	0	0	0	0	1,224	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	(16,546)	1,529	0	0	0	0	0	0	0	0	(15,017)	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	(10,211)	(251,317)	19,052	0	0	0	0	0	0	0	0	(242,476)	19
20	Fees, Subscriptions & Promotions	(7,764)	0	9,485	0	0	0	0	0	0	0	0	1,721	20
21	Clerical & General Office Expenses	0	0	290,197	0	0	0	0	0	0	0	0	290,197	21
22	Employee Benefits & Payroll Taxes	0	0	39,164	0	0	0	0	0	0	0	0	39,164	22
23	Inservice Training & Education	0	0	1,200	0	0	0	0	0	0	0	0	1,200	23
24	Travel and Seminar	(4,871)	0	6,199	0	0	0	0	0	0	0	0	1,328	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	16,429	0	0	0	0	0	0	0	0	16,429	26
27	Other (specify):*	(90,736)	0	0	0	0	0	0	0	0	0	0	(90,736)	27
28	TOTAL General Administration	(113,582)	(251,317)	381,726	0	0	0	0	0	0	0	0	16,827	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(113,582)	(267,863)	410,598	0	0	0	0	0	0	0	0	29,153	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Carlinville # 0048850 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	163,718	0	27,020	0	0	0	0	0	0	0	190,738	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(129)	29,545	0	290	0	0	0	0	0	0	0	29,706	32
33	Real Estate Taxes	0	34,678	0	0	0	0	0	0	0	0	0	34,678	33
34	Rent-Facility & Grounds	0	(473,040)	0	5,869	0	0	0	0	0	0	0	(467,171)	34
35	Rent-Equipment & Vehicles	0	0	0	8,845	0	0	0	0	0	0	0	8,845	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(129)	(245,099)	0	42,024	0	0	0	0	0	0	0	(203,204)	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	(71,956)	0	0	0	0	0	0	0	0	0	(71,956)	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	(71,956)	0	0	0	0	0	0	0	0	0	(71,956)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(113,711)	(584,918)	410,598	42,024	0	0	0	0	0	0	0	(246,007)	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

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%	\$ (16,546)	\$ (16,546)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(71,956)	(71,956)	3
4	V	19	Adjustment for Related Organization	251,317	Heritage Operations Group, LLC	0.00%		(251,317)	4
5	V								5
6	V	34	Adjustment for Related Organization	473,040	Heritage Manor Real Estate, LLC	0.00%		(473,040)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		34,678	34,678	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		27,437	27,437	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		163,718	163,718	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,108	2,108	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 724,357			\$ 139,439	\$ * (584,918)	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		\$	\$ 4,970	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					36	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,544	19
20	V	6	Maintenance					20,793	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					305	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,224	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					19,052	31
32	V	20	Fees, Subscription, Promotions					9,485	32
33	V	21	Clerical & General Office Expenses					290,197	33
34	V	22	Employee Benefits & Payroll Taxes					39,164	34
35	V	23	Inservice Training & Education					1,200	35
36	V	24	Travel and Seminar					6,199	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					16,429	38
39	Total			\$			\$ 0	\$ * 410,598	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					27,020	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					290	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,869	20
21	V	35	Rent-Equipment & Vehicles					8,845	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	\$ * 42,024	39

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

Facility Name & ID Number Heritage Health Carlinville # 0048850 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 Carlinville# 0048850

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	95	\$ 4,970	1
2	2	Food Purchase	Beds	2,571	26	0	0	95	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	95	36	3
4	4	Laundry	Beds	2,571	26	0	0	95	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	95	1,544	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	95	20,793	6
7	7	Other	Beds	2,571	26	0	0	95	0	7
8	9	Medical Director	Beds	2,571	26	0	0	95	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	95	305	9
10	11	Activities	Beds	2,571	26	0	0	95	0	10
11	12	Social Service	Beds	2,571	26	0	0	95	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	95	1,224	12
13	14	Program Transportation	Beds	2,571	26	0	0	95	0	13
14	15	Other	Beds	2,571	26	0	0	95	0	14
15	17	Administrative	Beds	2,571	26	0	0	95	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	95	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	95	19,052	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	95	9,485	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	95	290,197	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	95	39,164	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	95	1,200	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	95	6,199	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	95	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	95	16,429	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 410,598	25

Facility Name & ID Number Heritage Health Carlinville # 0048850 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	\$	\$	95	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		95	27,020	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			95		3
4	32	Interest	Beds	2,571	26	7,851		95	290	4
5	33	Real Estate Taxes	Beds	2,571	26			95		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		95	5,869	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		95	8,845	7
8	36	Other	Beds	2,571	26			95		8
9	38	Medically Nec Transportation	Beds	2,571	26			95		9
10	39	Ancillary Service Centers	Beds	2,571	26			95		10
11	40	Barber and Beauty Shops	Beds	2,571	26			95		11
12	41	Coffee and Gift Shops	Beds	2,571	26			95		12
13	42	Other	Beds	2,571	26			95		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	\$		\$ 42,024	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	Mortgage			\$		\$			\$	27,437	1					
2	Bank of America		x	Loan Fee Amortization									2,108	2					
3														3					
4														4					
5														5					
	Working Capital																		
6	Bank of America		x	Working Capital									44,828	6					
7														7					
8														8					
9	TOTAL Facility Related						\$		\$			\$	74,373	9					
	B. Non-Facility Related*																		
10	Interest Income												(129)	10					
11														11					
12	Allocated Corporate												290	12					
13														13					
14	TOTAL Non-Facility Related						\$		\$			\$	161	14					
15	TOTALS (line 9+line14)						\$		\$			\$	74,534	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$34,678	2
3. Under or (over) accrual (line 2 minus line 1).				\$34,678	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.				\$34,678	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	32,778	8	
		2012	33,430	9	
		2013	33,716	10	
		2014	34,371	11	
		2015	34,678	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 Carlinville COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0048850

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

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.

A. Square Feet:

34,320

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				\$ 32,017	1
2					2
3	TOTALS			\$ 32,017	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	95				\$ 3,265,145	\$		\$		\$
5										
6										
7										
8										
	Improvement Type**									
9	Heritage Manor Sign			1996	2,176					
10	Architect Fees			1996	2,387					
11	Laundry Room Electrical Repair			1996	3,019					
12										
13										
14	Special Care Unit -- Remodel			1997	30,884					
15										
16	Remodel-- Alzheimer Wing			1998	78,813					
17	A/C Unit			1998	950					
18	Life Safety Improvements			1998	7,351					
19	Shower Room Remodel			1998	2,811					
20	Roof Replacement			1998	92,246					
21										
22	Door Alarm			1999	2,317					
23	Smoke Damperer			1999	498					
24	Water System			1999	8,115					
25	Interior Painting--Material and Labor			1999	6,892					
26	Shower Room Remodel			1999	2,453					
27	Water Heater			1999	4,253					
28										
29										
30										
31										
32										
33	C/O Allocation					27,020		27,020		
34	Book Depreciation					146,806		146,806		
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 & ID Number Heritage Health Carlinville

0048850

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	
37	Water Softener	2000	\$ 3,802	\$		\$	\$	\$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	10,318						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,638,207	\$ 173,826		\$ 173,826	\$	\$	70

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

Facility Name & ID Number Heritage Health Carlinville

0048850

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 12A, Carried Forward		\$ 3,638,207	\$ 173,826		\$ 173,826	\$	\$	1
2	Window Replacement	2005	371						2
3	HVAC	2005	10,165						3
4	Rooftop A/C	2005	8,997						4
5	Water Storage Tank	2005	4,456						5
6	Rooftop Heater	2005	3,425						6
7									7
8	Sidewalk	2006	630						8
9	Parking Lot Sealer	2006	2,385						9
10	Window Replacement	2006	1,638						10
11	Resident room remodel -- paint, wall coverings	2006	3,390						11
12	Smoke detectors	2006	1,644						12
13									13
14	Resident room remodel -- paint, wall coverings	2007	4,207						14
15	Corridor Rehab -- Paint/Wallpaper	2007	22,058						15
16	HVAC	2007	9,819						16
17	Fire Alarm	2007	2,900						17
18	Rosedale Corridor Rehab-- Paint/ Wallpaper	2007	4,041						18
19	Sprinkler System	2007	3,398						19
20									20
21									21
22	Rosedale Resident room Rehab -- Paint/Wallpaper	2007	26,384						22
23	Rooftop A/C	2007	4,417						23
24	Kitchen Repairs	2007	1,550						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)		\$ 3,754,082	\$ 173,826		\$ 173,826	\$	\$	34

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

Facility Name & ID Number Heritage Health Carlinville

0048850

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 12B, Carried Forward		\$ 3,754,082	\$ 173,826		\$ 173,826	\$	\$	1
2 PTAC Units	2008	7,980						2
3 Nurse call/Phone System	2008	157,428						3
4 Kitchen Water Heater	2008	2,600						4
5 Rosedale wing room remodel-- paint/flooring	2008	15,673						5
6 Kitchen plumbing	2008	3,130						6
7 Sprinkler	2008	5,972						7
8 Legacy Unit Remodel--paint/flooring	2008	37,068						8
9 Fire Alarm	2008	47,279						9
10								10
11 Sewer Line	2009	6,355						11
12 Therapy Renovation: paint, electrical, flooring	2009	76,398						12
13 Kitchen pipe	2009	2,700						13
14 Shower	2009	5,080						14
15 Door Alarms	2009	42,322						15
16 Nurse call/Phone System	2009	35,992						16
17 Fire Alarm	2009	15,451						17
18								18
19 Concrete Work & Install Curtins -- therapy room	2010	3,904						19
20 PTAC Units	2010	3,530						20
21 Flooring/Installation Shower room floor	2010	20,394						21
22								22
23 Electric Heat/Cool unit	2011	5,500						23
24 500 gallon grease trap	2011	3,300						24
25 Parking Lot seal	2011	9,481						25
26 Kitchen Exhaust hood	2011	5,500						26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,267,119	\$ 173,826		\$ 173,826	\$	\$	34

**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 12C, Carried Forward		\$ 4,267,119	\$ 173,826		\$ 173,826	\$	\$	1
2								2
3 Kitchen Rehab - Flooring	2013	19,580						3
4 Lighting Retrofit	2013	7,269						4
5 A/C Units	2013	2,592						5
6 Walk in Cooler- Freezer	2013	25,216						6
7 Install Dry Sidewalls in Therapy	2013	3,200						7
8								8
9 Walk in Cooler- Freezer - Final Installment	2014	5,791						9
10 Door Closures	2014	3,483						10
11 Rooftop AC System Install	2014	8,950						11
12 Install Split System	2014	7,609						12
13 Parking Lot Fill, Seal and Stripe	2014	6,939						13
14 Replace Boiler and Water Tank	2014	9,928						14
15								15
16 Replace (6) PTAC units	2015	6,004						16
17 Repalce roof top refrigeration unit over dining room	2015	9,808						17
18 Repalcement of exhaust fans 1-5	2015	6,777						18
19								19
20 No 2016 Improvements								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,390,265	\$ 173,826		\$ 173,826	\$	\$	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	\$764,459	\$16,912	\$16,912	\$		\$	71
72	Current Year Purchases	11,623						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$776,082	\$16,912	\$16,912	\$		\$	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$5,198,364
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$190,738
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$190,738
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:☐ YES☒ NO Terms: *

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: \$6,381 Description:Televisions and office machines
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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.
- (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.

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	

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	\$		\$ 323,141	\$		\$ 323,141	1
2	Licensed Speech and Language Development Therapist		hrs			13,955			13,955	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			256,092	532		256,624	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				375,408		375,408	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,174			9,174	13
14	TOTAL			\$		\$ 602,362	\$ 375,940		\$ 978,302	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	\$ 7,807	\$	1
2	Cash-Patient Deposits	17,193		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,352,620		3
4	Supply Inventory (priced at)	13,118		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,227		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,726,713)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,308,748)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,308,748)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 149,437	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,193		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,747		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,760		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>	29,069		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 461,206	\$	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)	\$ 461,206	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,769,954)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,308,748)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,354,981)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,354,981)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	585,027	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)	\$ 585,027	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,769,954)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Carlinville

0048850

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	\$ 5,407,751	1
2	Discounts and Allowances for all Levels	(1,919,500)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,488,251	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,755,108	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,755,108	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	737	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	735,931	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	24,546	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 761,214	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	129	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 129	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)	\$ 6,004,702	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	936,129	31
32	Health Care	2,031,485	32
33	General Administration	1,334,327	33
	B. Capital Expense		
34	Ownership	524,249	34
	C. Ancillary Expense		
35	Special Cost Centers	593,485	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)*	\$ 5,419,675	40
41	Income before Income Taxes (line 30 minus line 40)**	585,027	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 585,027	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	1,364	1,436	\$ 43,672	\$ 30.41	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,054	4,267	122,909	28.80	3
4	Licensed Practical Nurses	16,173	17,024	409,256	24.04	4
5	CNAs & Orderlies	58,572	61,655	763,975	12.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,467	3,650	86,141	23.60	8
9	Activity Director					9
10	Activity Assistants	4,989	5,252	75,719	14.42	10
11	Social Service Workers	1,841	1,938	35,934	18.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,371	18,285	199,871	10.93	15
16	Dishwashers					16
17	Maintenance Workers	4,321	4,549	65,714	14.45	17
18	Housekeepers	10,269	10,810	111,153	10.28	18
19	Laundry	6,010	6,326	65,752	10.39	19
20	Administrator	1,984	2,088	68,850	32.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,595	6,942	154,085	22.20	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)	137,010	144,222	\$ 2,203,031 *	\$ 15.28	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		14,500		36
37	Medical Records Consultant		590		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,516		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		4,028		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,634		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHeritage Health Carlinville# 0048850Report Period Beginning:01/01/16Ending:12/31/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donna Weeks			\$ 68,850
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,850

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt services	\$ 251,317
ADP	Payroll Tax Processing	1,248
Tango Inc	ACA Compliance	675
McKee Environmental	Inspection	920
MPRO	Records consulting	2,880
Legal adj to Zero		10,211
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 267,251

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 42,579	
Unemployment Compensation Insurance	26,883	
FICA Taxes	168,532	
Employee Health Insurance	166,647	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Other Benefits	11,416	
Central Office Allocation	39,164	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 455,221

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	7,074	
Health Care Worker Background Check (Indicate # of checks performed)	1,326	
PR	3,662	
Dues & Subscriptions	10,129	
License & Fees	5,152	
Central Office Allocation	9,485	
Less: Public Relations Expense	(3,662)	
Non-allowable advertising	(3,873)	
Yellow page advertising (	)	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,293

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	2,663
	113
Seminar Expense	895
	1,328
Entertainment Expense (	)
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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?
If YES, give association name and amount.

Yes
HCCI

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
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?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 218,824

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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? (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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 1,191

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ 0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees

None Claimed

HFS 3745 (N-4-99)

IL478-2471

GRAND TOTAL	DEBIT	CREDIT	-111,761
FACTORY NAME:	0		
FACTORY ID:	0		
FACTORY UNIT:	00		
BALANCE SHEET TOTAL	0		
OFF	CU	RECAP CENTER	
00	13,500	13,500	
00	10,000	10,000	
00000000	2,500	2,500	

Heritage Manor Carlinville
HFS ID# 205508113001
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	(53,793)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(165,031)
		<u>(218,824)</u>
		<u><u>(218,824)</u></u>
Provider Participation Fee	Line 42	218,824
		<u><u>218,824</u></u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(375,408)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(9,174)
		<u>(384,582)</u>
		<u><u>(384,582)</u></u>
Ancillary Service Centers	Line 39	384,582
		<u><u>384,582</u></u>