

		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: 0048868

Facility Name: Heritage Health Chillicothe

Address: 1028 Hillcrest Drive Chillicothe 61523
Number City Zip Code

County: Peoria

Telephone Number: (309) 274-2194 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

x PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
x 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 Chillicothe

0048868 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 <u>7/26/16</u>					
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>110</u>	Skilled (SNF)	<u>106</u>	<u>39,264</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>110</u>	TOTALS	<u>106</u>	<u>39,264</u>	<u>7</u>

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,997</u>	<u>9,259</u>	<u>3,054</u>	<u>29,310</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>16,997</u>	<u>9,259</u>	<u>3,054</u>	<u>29,310</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.65%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 3,054

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 Chillicothe # 0048868 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	236,926	12,935		249,861		249,861	5,545	255,406			1
2	Food Purchase		220,209		220,209		220,209		220,209			2
3	Housekeeping	91,351	25,964		117,315		117,315	40	117,355			3
4	Laundry	41,622	12,772		54,394		54,394		54,394			4
5	Heat and Other Utilities			74,281	74,281		74,281	1,723	76,004			5
6	Maintenance	62,023	48,471	83,013	193,507		193,507	23,200	216,707			6
7	Other (specify):*											7
8	TOTAL General Services	431,922	320,351	157,294	909,567		909,567	30,508	940,075			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,834,450	157,361	89,792	2,081,603		2,081,603	(22,406)	2,059,197			10
10a	Therapy		720,510	17,572	738,082	(735,016)	3,066		3,066			10a
11	Activities	93,079	4,931		98,010		98,010		98,010			11
12	Social Services	31,432		1,028	32,460		32,460		32,460			12
13	CNA Training	2,238	1,472		3,710		3,710	1,366	5,076			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,961,199	884,274	120,392	2,965,865	(735,016)	2,230,849	(21,040)	2,209,809			16
	C. General Administration											
17	Administrative	85,000			85,000		85,000		85,000			17
18	Directors Fees											18
19	Professional Services			315,217	315,217		315,217	(291,931)	23,286			19
20	Dues, Fees, Subscriptions & Promotions			340,532	340,532	(220,097)	120,435	(69,502)	50,933			20
21	Clerical & General Office Expenses	209,835	16,359	14,933	241,127		241,127	323,798	564,925			21
22	Employee Benefits & Payroll Taxes			474,954	474,954		474,954	43,699	518,653			22
23	Inservice Training & Education			7,260	7,260		7,260	1,339	8,599			23
24	Travel and Seminar			13,699	13,699		13,699	(8,700)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,275	55,275		55,275	18,331	73,606			26
27	Other (specify):*			160,382	160,382		160,382	(160,382)				27
28	TOTAL General Administration	294,835	16,359	1,382,252	1,693,446	(220,097)	1,473,349	(143,348)	1,330,001			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,687,956	1,220,984	1,659,938	5,568,878	(955,113)	4,613,765	(133,880)	4,479,885			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							385,031	385,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,945	49,945		49,945	177,963	227,908			32
33	Real Estate Taxes							82,848	82,848			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(475,252)	6,548			34
35	Rent-Equipment & Vehicles			15,269	15,269		15,269	9,869	25,138			35
36	Other (specify):*											36
37	TOTAL Ownership			547,014	547,014		547,014	180,459	727,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			755,353	755,353	735,016	1,490,369	(235,252)	1,255,117			39
40	Barber and Beauty Shops			7,813	7,813		7,813		7,813			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					220,097	220,097		220,097			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			763,166	763,166	955,113	1,718,279	(235,252)	1,483,027			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,687,956	1,220,984	2,970,118	6,879,058		6,879,058	(188,673)	6,690,385			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	(2,804)			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	(15,617)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,655)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,382)			24
25	Fund Raising, Advertising and Promotional	(80,085)			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)	\$ (282,543)		\$	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)	93,870		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 93,870		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (188,673)		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		(23,655)	19	22
23				23
24		(160,382)	27	24
25		(80,085)	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	(264,122)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	5,545	0	0	0	0	0	0	0	0	5,545	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	40	0	0	0	0	0	0	0	0	40	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,723	0	0	0	0	0	0	0	0	1,723	5
6	Maintenance	0	0	23,200	0	0	0	0	0	0	0	0	23,200	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	30,508	0	0	0	0	0	0	0	0	30,508	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	(22,746)	340	0	0	0	0	0	0	0	0	(22,406)	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	1,366	0	0	0	0	0	0	0	0	1,366	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	(22,746)	1,706	0	0	0	0	0	0	0	0	(21,040)	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	(23,655)	(289,535)	21,259	0	0	0	0	0	0	0	0	(291,931)	19
20	Fees, Subscriptions & Promotions	(80,085)	0	10,583	0	0	0	0	0	0	0	0	(69,502)	20
21	Clerical & General Office Expenses	0	0	323,798	0	0	0	0	0	0	0	0	323,798	21
22	Employee Benefits & Payroll Taxes	0	0	43,699	0	0	0	0	0	0	0	0	43,699	22
23	Inservice Training & Education	0	0	1,339	0	0	0	0	0	0	0	0	1,339	23
24	Travel and Seminar	(15,617)	0	6,917	0	0	0	0	0	0	0	0	(8,700)	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	18,331	0	0	0	0	0	0	0	0	18,331	26
27	Other (specify):*	(160,382)	0	0	0	0	0	0	0	0	0	0	(160,382)	27
28	TOTAL General Administration	(279,739)	(289,535)	425,926	0	0	0	0	0	0	0	0	(143,348)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(279,739)	(312,281)	458,140	0	0	0	0	0	0	0	0	(133,880)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	354,882	0	30,149	0	0	0	0	0	0	0	385,031	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,804)	180,443	0	324	0	0	0	0	0	0	0	177,963	32
33	Real Estate Taxes	0	82,848	0	0	0	0	0	0	0	0	0	82,848	33
34	Rent-Facility & Grounds	0	(481,800)	0	6,548	0	0	0	0	0	0	0	(475,252)	34
35	Rent-Equipment & Vehicles	0	0	0	9,869	0	0	0	0	0	0	0	9,869	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,804)	136,373	0	46,890	0	0	0	0	0	0	0	180,459	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	(235,252)	0	0	0	0	0	0	0	0	0	(235,252)	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	(235,252)	0	0	0	0	0	0	0	0	0	(235,252)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(282,543)	(411,160)	458,140	46,890	0	0	0	0	0	0	0	(188,673)	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%	\$ (22,746)	\$ (22,746)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(235,252)	(235,252)	3
4	V	19	Adjustment for Related Organization	289,535	Heritage Operations Group, LLC	0.00%		(289,535)	4
5	V								5
6	V	34	Adjustment for Related Organization	481,800	Heritage Manor Real Estate, LLC	0.00%		(481,800)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		82,848	82,848	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		163,496	163,496	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		354,882	354,882	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		16,947	16,947	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 771,335			\$ 360,175	\$ * (411,160)	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		\$	5,545	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					40	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,723	19
20	V	6	Maintenance					23,200	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					340	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,366	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					21,259	31
32	V	20	Fees, Subscription, Promotions					10,583	32
33	V	21	Clerical & General Office Expenses					323,798	33
34	V	22	Employee Benefits & Payroll Taxes					43,699	34
35	V	23	Inservice Training & Education					1,339	35
36	V	24	Travel and Seminar					6,917	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					18,331	38
39	Total			\$			\$ 0	\$ * 458,140	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					30,149	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					324	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,548	20
21	V	35	Rent-Equipment & Vehicles					9,869	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	\$ * 46,890	39

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number Heritage Health Chillicothe# 0048868

Report Period Beginning:

01/01/16Ending: 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	106	\$ 5,545	1
2	2	Food Purchase	Beds	2,571	26	0	0	106	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	106	40	3
4	4	Laundry	Beds	2,571	26	0	0	106	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	106	1,723	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	106	23,200	6
7	7	Other	Beds	2,571	26	0	0	106	0	7
8	9	Medical Director	Beds	2,571	26	0	0	106	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	106	340	9
10	11	Activities	Beds	2,571	26	0	0	106	0	10
11	12	Social Service	Beds	2,571	26	0	0	106	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	106	1,366	12
13	14	Program Transportation	Beds	2,571	26	0	0	106	0	13
14	15	Other	Beds	2,571	26	0	0	106	0	14
15	17	Administrative	Beds	2,571	26	0	0	106	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	106	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	106	21,259	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	106	10,583	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	106	323,798	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	106	43,699	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	106	1,339	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	106	6,917	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	106	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	106	18,331	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 458,140	25

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	\$	\$	106	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		106	30,149	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			106		3
4	32	Interest	Beds	2,571	26	7,851		106	324	4
5	33	Real Estate Taxes	Beds	2,571	26			106		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		106	6,548	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		106	9,869	7
8	36	Other	Beds	2,571	26			106		8
9	38	Medically Nec Transportation	Beds	2,571	26			106		9
10	39	Ancillary Service Centers	Beds	2,571	26			106		10
11	40	Barber and Beauty Shops	Beds	2,571	26			106		11
12	41	Coffee and Gift Shops	Beds	2,571	26			106		12
13	42	Other	Beds	2,571	26			106		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	\$		\$ 46,890	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	Busey Bank		x	Mortgage			\$				\$	163,496	1
2	Busey Bank		x	Loan Fee Amortization								16,947	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x	Line of credit								49,945	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	230,388	9
	B. Non-Facility Related*												
10	Interest Income											(2,804)	10
11													11
12	Allocated Corporate											324	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(2,480)	14
15	TOTALS (line 9+line14)						\$				\$	227,908	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.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Heritage Health Chillicothe

COUNTY

Peoria

FACILITY IDPH LICENSE NUMBER

0048868

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 0529376016		\$ 81,567.02	\$ 81,567.00
2. 0529376017		\$ 1,280.60	\$ 1,281.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 82,847.62	\$ 82,848.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 42,914

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 Chillicothe LLC - Assisted living (53 units) and Memory Care (20 units). Property is adjacent only-no sharing.
Relation is only through common ownership.

E. 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				\$ 129,000	1
2					2
3	TOTALS			\$ 129,000	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	106				\$ 3,301,403	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Awning		1998		2,334					9
10	Heritage Sign		1998		1,860					10
11	Chiller Replacement		1998		54,444					11
12										12
13	Interior Remodel--Materials		1999		154,576					13
14			1999							14
15	Interior Remodel--Professional Fees		1999		24,247					15
16										16
17	Water Heater controls		2000		1,347					17
18	Water Heater		2000		57,254					18
19	Door Locks		2000		1,997					19
20	Heat / Cool Fan		2000		1,598					20
21	Fire Alarm System		2000		4,400					21
22	Alzheimer Unit -- Professional Fees		2000		25,115					22
23	Interior Remodel--Materials (see attached)		2000		93,951					23
24	Interior Remodel--Labor (see attached)		2000		23,130					24
25	Interior Remodel--Professional Fees (see attached)		2000		5,762					25
26										26
27	Water Softener		2001		4,246					27
28	Boiler		2001		29,350					28
29	Door Holders		2001		654					29
30	Alzheimer Unit -- Professional Fees		2001		4,660					30
31										31
32										32
33	C/O Allocation					30,149		30,149		33
34	Book Depreciation					304,791		304,791		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 Chillicothe

0048868

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpet	2002	\$ 2,373	\$		\$	\$	\$	37
38	Compressor	2002	1,164						38
39	Compressor	2002	7,234						39
40	Windows	2002	1,722						40
41									41
42	Storge Tank	2003	737						42
43	In-sink Aerator	2003	810						43
44	Boiler	2003	16,393						44
45	Carpet	2003	2,839						45
46									46
47	Smoke detectors	2004	2,285						47
48	Dinning Room Waitress	2004	2,617						48
49	Parking Lot Sealcoat	2004	4,926						49
50	Boiler Pipe	2004	3,775						50
51	Auto Trans Switch	2004	16,847						51
52	Day Room	2004	1,778						52
53									53
54	Day Room	2005	8,753						54
55	Boiler	2005	19,619						55
56	Fire Alarm	2005	1,628						56
57	Resident Room Carpet	2005	698						57
58	Security System	2005	6,393						58
59	Breaker Replacement	2005	1,980						59
60	Condenser	2005	1,118						60
61	Roof	2005	188,466						61
62	Wiring	2005	820						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,087,303	\$ 334,940		\$ 334,940	\$	\$	70

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

Facility Name & ID Number Heritage Health Chillicothe

0048868

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 12A, Carried Forward		\$ 4,087,303	\$ 334,940		\$ 334,940	\$	\$	1
2 Heat pump	2006	5,669						2
3 Boiler	2006	72,981						3
4 fire Alarm	2006	3,553						4
5 Roof	2006	1,300						5
6 Kitchen remodel	2006	4,623						6
7 Carpet	2006	1,139						7
8 Condensing Unit	2006	2,000						8
9 East Wing Dinning Room Remodel	2006	5,228						9
10								10
11 East Wing Remodel-- paint, floors	2007	23,281						11
12 Boiler	2007							12
13 Fire Alarm	2007							13
14 Generator	2007							14
15 Code Alert	2007	4,622						15
16 Fence	2007	3,089						16
17 Landscapping	2007							17
18 Parking Lot sealer	2007	5,000						18
19 Generator	2007	8,260						19
20 Heat pump	2007	21,969						20
21 Water Line	2007							21
22								22
23 East Wing Remodel-- paint, floors	2008	61,290						23
24 Sprinkler Backflow	2008	4,360						24
25 Heat pump	2008	16,046						25
26 Soiled Utility/Med Room	2008	2,622						26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,334,335	\$ 334,940		\$ 334,940	\$	\$	34

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

Facility Name & ID Number Heritage Health Chillicothe

0048868

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		\$ 4,334,335	\$ 334,940		\$ 334,940	\$	\$	1
2									2
3	<u>Window replacements</u>	2009	64,129						3
4									4
5	<u>HVAC</u>	2009	6,180						5
6	<u>Heat Pump</u>	2009	26,052						6
7	<u>Nurse Call system</u>	2009	226,889						7
8									8
9	<u>Chiller</u>	2010	3,429						9
10	<u>Data Equipment Relocation</u>	2010	2,658						10
11	<u>Roof</u>	2010	129,751						11
12	<u>Paint, flooring & Labor Dining Room</u>	2010	7,567						12
13									13
14	<u>Sprinkler system</u>	2011	77,240						14
15	<u>Coil Unit</u>	2011	3,744						15
16	<u>Fluid cooler</u>	2011	40,567						16
17	<u>Exhaust fans</u>	2011	7,141						17
18	<u>Concrete walkway</u>	2011	10,067						18
19	<u>Remodel Adminstror's office</u>	2011	3,200						19
20	<u>Sign</u>	2011	19,723						20
21	<u>Boiler</u>	2011	13,577						21
22									22
23	<u>Lighting Upgrade</u>	2012	6,143						23
24	<u>Boiler</u>	2012	15,051						24
25									25
26	<u>Boiler Replacement Final Payment</u>	2013	3,132						26
27	<u>Labor - Interior design of planned facility renovation</u>	2013	12,052						27
28	<u>Ceiling Replacement - Removal of old ceiling & asbestos</u>	2013	46,400						28
29	<u>Ceiling Replacement - Labor and materials to install new</u>	2013	18,882						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,077,909	\$ 334,940		\$ 334,940	\$	\$	34

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

Facility Name & ID Number Heritage Health Chillicothe

0048868

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 12C, Carried Forward		\$ 5,077,909	\$ 334,940		\$ 334,940	\$	\$	1
2									2
3	Install Boiler Pump	2014	2,700						3
4	Install New Compresspr	2014	3,675						4
5	Install New Disposal	2014	2,634						5
6									6
7	Replaced kitchen garbage disposal	2015	2,914						7
8	Boiler- Replaced pressure regulator and relief valve	2015	5,392						8
9									9
10	Install flood lights for the back parking lot	2016	2,926						10
11	Landscaping front parking lot and front entrance -	2016	10,585						11
12	removing previous materials and replacing with new								12
13	mulch, topsoil, bricks and plants								13
14									14
15	Full Facility Renovation Project -	2016	2,653,564						15
16	Each of the 54 Patient Rooms received New Flooring, Cabinetry, Furniture								16
17	(including beds), wallcover removal and fresh painting								17
18	New Flooring in all hallways and other common areas;								18
19	New Tables and Chairs in both dining areas; New Cabinets								19
20	and Flooring for both Nursing Stations; New Plumbing								20
21	fixtures throughout entire facility;								21
22	Constructed a new dining area - 852 square foot contiguous								22
23	addition to existing building;								23
24	Relocated existing therapy unit to old dining room-installed new flooring and equipment								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)		\$ 7,762,299	\$ 334,940		\$ 334,940	\$	\$	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	\$816,472	\$50,091	\$50,091	\$		\$	71
72	Current Year Purchases	227,428						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,043,900	\$50,091	\$50,091	\$		\$	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		2006 Turtletop Van	2006	\$57,088	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$57,088	\$	\$	\$		\$

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)			\$	8,992,287
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	385,031
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	385,031
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: \$15,269Description:Televisions and office equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

* 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		1,472		1,472
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,238		2,238
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 3,710	\$	\$ 3,710
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,710			

- (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	\$		\$ 337,595	\$		\$ 337,595	1
2	Licensed Speech and Language Development Therapist		hrs			24,396			24,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			393,362	3,066		396,428	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				717,444		717,444	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,572			17,572	13
14	TOTAL			\$		\$ 772,925	\$ 720,510		\$ 1,493,435	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	\$ 55,313	\$	1
2	Cash-Patient Deposits	25,566		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,566,617		3
4	Supply Inventory (priced at)	1,869		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,109		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(778,067)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 901,407	\$	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)	\$ 901,407	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 239,081	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,566		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,218		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,145		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	27,497		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 484,507	\$	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)	\$ 484,507	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 416,900	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 901,407	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 396,912	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 396,912	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	19,988	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)	\$ 19,988	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)	\$ 416,900	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Chillicothe

0048868

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	\$ 5,919,676	1
2	Discounts and Allowances for all Levels	(2,554,565)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,365,111	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,235,200	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,235,200	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	462	12
13	Barber and Beauty Care	7,729	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,284,008	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,732	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,295,931	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,804	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,804	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)	\$ 6,899,046	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	909,567	31
32	Health Care	2,965,865	32
33	General Administration	1,693,446	33
	B. Capital Expense		
34	Ownership	547,014	34
	C. Ancillary Expense		
35	Special Cost Centers	763,166	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)*	\$ 6,879,058	40
41	Income before Income Taxes (line 30 minus line 40)**	19,988	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 19,988	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	1,490	1,568	\$ 67,550	\$ 43.08	1
2	Assistant Director of Nursing	2,448	2,577	89,758	34.83	2
3	Registered Nurses	10,745	11,311	364,636	32.24	3
4	Licensed Practical Nurses	12,155	12,795	342,883	26.80	4
5	CNAs & Orderlies	60,120	63,284	914,693	14.45	5
6	CNA Trainees	248	261	2,238	8.57	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,127	2,239	54,930	24.53	8
9	Activity Director					9
10	Activity Assistants	6,552	6,897	93,079	13.50	10
11	Social Service Workers	1,768	1,861	31,432	16.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,236	20,248	236,926	11.70	15
16	Dishwashers					16
17	Maintenance Workers	2,856	3,006	62,023	20.63	17
18	Housekeepers	7,629	8,031	91,351	11.37	18
19	Laundry	3,747	3,944	41,622	10.55	19
20	Administrator	1,984	2,088	85,000	40.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,112	9,592	209,835	21.88	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)	142,217	149,702	\$ 2,687,956 *	\$ 17.96	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		12,000		36
37	Medical Records Consultant		1,197		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,845		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		1,028		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,070		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		69,560		51
52	Certified Nurse Assistants/Aides		16,351		52
53	TOTAL (lines 50 - 52)		\$ 85,911		53

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

** See instructions.

Facility Name & ID Number		Heritage Health Chillicothe		STATE OF ILLINOIS		# 0048868		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			
Melissa Stachowiak						\$ 85,000		Workers' Compensation Insurance		\$ 67,682		IDPH License Fee		\$			
								Unemployment Compensation Insurance		30,194		Advertising: Employee Recruitment		23,393			
								FICA Taxes		205,629		Health Care Worker Background Check					
								Employee Health Insurance		138,940		(Indicate # of checks performed)		2,578			
								Employee Meals									
								Illinois Municipal Retirement Fund (IMRF)*									
												PR		26,847			
TOTAL (agree to Schedule V, line 17, col. 1)								Other Benefits		32,509		Dues & Subscriptions		13,432			
(List each licensed administrator separately.)						\$ 85,000		Central Office Allocation		43,699		License & Fees		5,564			
B. Administrative - Other												Central Office Allocation				10,583	
Description						Amount						Less: Public Relations Expense		(26,847)			
						\$						Non-allowable advertising		(4,617)			
												Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 3)						\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 518,653		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 50,933			
(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				\$ 289,534						\$		Out-of-State Travel		\$	
ADP		Payroll tax processing				1,331											
Tango Inc		ACA compliance				697											
														In-State Travel			
																11,678	
																270	
														Seminar Expense		1,751	
																(8,700)	
Legal adj to Zero						23,655								Entertainment Expense		()	
														(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)						\$ 315,217		TOTAL		\$		TOTAL				\$ 4,999	
(For legal fee disclosure, see page 39 of instructions)																	
* Attach copy of IMRF notifications																	
**See instructions.																	

Facility Name & ID Number <u>Heritage Health Chillicothe</u>	STATE OF ILLINOIS # <u>0048868</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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Page 22

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. \$ 220,097
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0

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

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

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

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

Heritage Manor Chillicothe
HFS ID# 205412664001
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	(59,436)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(160,661)
		<u>(220,097)</u>
Provider Participation Fee	Line 42	<u>220,097</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(717,444)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(17,572)
		<u>(735,016)</u>
Ancillary Service Centers	Line 39	<u>735,016</u>