

		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: 0048132

Facility Name: Heritage Health Elgin

Address: 355 Raymond Street Elgin 60120
Number City Zip Code

County: Kane

Telephone Number: (847) 697-6636 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2006

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 Elgin

0048132 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,404	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	94	TOTALS	94	34,404	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	22,902	2,746	2,120	27,768	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,902	2,746	2,120	27,768	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.71%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/2006

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 2,120

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 Elgin # 0048132 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	268,641	19,291		287,932		287,932	4,917	292,849			1
2	Food Purchase		206,828		206,828		206,828		206,828			2
3	Housekeeping	148,457	46,664		195,121		195,121	35	195,156			3
4	Laundry	29,363	21,129		50,492		50,492		50,492			4
5	Heat and Other Utilities			102,979	102,979		102,979	1,528	104,507			5
6	Maintenance	119,109	63,756	68,427	251,292		251,292	20,574	271,866			6
7	Other (specify):*											7
8	TOTAL General Services	565,570	357,668	171,406	1,094,644		1,094,644	27,054	1,121,698			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,981,034	77,607	46,322	2,104,963		2,104,963	(15,993)	2,088,970			10
10a	Therapy		387,812	8,123	395,935	(392,864)	3,071		3,071			10a
11	Activities	77,350	9,255		86,605		86,605		86,605			11
12	Social Services	42,248		3,192	45,440		45,440		45,440			12
13	CNA Training	7,762		5,640	13,402		13,402	1,211	14,613			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,108,394	474,674	75,277	2,658,345	(392,864)	2,265,481	(14,782)	2,250,699			16
	C. General Administration											
17	Administrative	114,993			114,993		114,993		114,993			17
18	Directors Fees											18
19	Professional Services			300,084	300,084		300,084	(277,804)	22,280			19
20	Dues, Fees, Subscriptions & Promotions			249,419	249,419	(212,546)	36,873	(15,171)	21,702			20
21	Clerical & General Office Expenses	324,525	28,579	38,265	391,369		391,369	287,142	678,511			21
22	Employee Benefits & Payroll Taxes			488,845	488,845		488,845	38,752	527,597			22
23	Inservice Training & Education			7,371	7,371		7,371	1,188	8,559			23
24	Travel and Seminar			7,951	7,951		7,951	(2,952)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,444	55,444		55,444	16,256	71,700			26
27	Other (specify):* Lost Resident Items			12,745	12,745		12,745	(11,580)	1,165			27
28	TOTAL General Administration	439,518	28,579	1,160,124	1,628,221	(212,546)	1,415,675	35,831	1,451,506			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,113,482	860,921	1,406,807	5,381,210	(605,410)	4,775,800	48,103	4,823,903			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							153,802	153,802			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,681	42,681		42,681	18,251	60,932			32
33	Real Estate Taxes							56,158	56,158			33
34	Rent-Facility & Grounds			411,720	411,720		411,720	(405,913)	5,807			34
35	Rent-Equipment & Vehicles			19,549	19,549	2,155	21,704	8,752	30,456			35
36	Other (specify):*											36
37	TOTAL Ownership			473,950	473,950	2,155	476,105	(168,950)	307,155			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			727,881	727,881	392,864	1,120,745	(69,438)	1,051,307			39
40	Barber and Beauty Shops			180	180		180		180			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					210,391	210,391		210,391			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			728,061	728,061	603,255	1,331,316	(69,438)	1,261,878			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,113,482	860,921	2,608,818	6,583,221		6,583,221	(190,285)	6,392,936			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	(461)			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	(9,086)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,465)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,580)			24
25	Fund Raising, Advertising and Promotional	(24,556)			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)	\$ (57,148)		\$	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)	(133,137)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (133,137)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (190,285)		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		(11,465)	19	22
23				23
24		(11,580)	27	24
25		(24,556)	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	(47,601)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Elgin # 0048132 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	4,917	0	0	0	0	0	0	0	0	4,917	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	35	0	0	0	0	0	0	0	0	35	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,528	0	0	0	0	0	0	0	0	1,528	5
6	Maintenance	0	0	20,574	0	0	0	0	0	0	0	0	20,574	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,054	0	0	0	0	0	0	0	0	27,054	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	(16,295)	302	0	0	0	0	0	0	0	0	(15,993)	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	1,211	0	0	0	0	0	0	0	0	1,211	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	(16,295)	1,513	0	0	0	0	0	0	0	0	(14,782)	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	(11,465)	(285,191)	18,852	0	0	0	0	0	0	0	0	(277,804)	19
20	Fees, Subscriptions & Promotions	(24,556)	0	9,385	0	0	0	0	0	0	0	0	(15,171)	20
21	Clerical & General Office Expenses	0	0	287,142	0	0	0	0	0	0	0	0	287,142	21
22	Employee Benefits & Payroll Taxes	0	0	38,752	0	0	0	0	0	0	0	0	38,752	22
23	Inservice Training & Education	0	0	1,188	0	0	0	0	0	0	0	0	1,188	23
24	Travel and Seminar	(9,086)	0	6,134	0	0	0	0	0	0	0	0	(2,952)	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	16,256	0	0	0	0	0	0	0	0	16,256	26
27	Other (specify):*	(11,580)	0	0	0	0	0	0	0	0	0	0	(11,580)	27
28	TOTAL General Administration	(56,687)	(285,191)	377,709	0	0	0	0	0	0	0	0	35,831	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(56,687)	(301,486)	406,276	0	0	0	0	0	0	0	0	48,103	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Elgin # 0048132 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	127,066	0	26,736	0	0	0	0	0	0	0	153,802	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(461)	18,425	0	287	0	0	0	0	0	0	0	18,251	32
33	Real Estate Taxes	0	56,158	0	0	0	0	0	0	0	0	0	56,158	33
34	Rent-Facility & Grounds	0	(411,720)	0	5,807	0	0	0	0	0	0	0	(405,913)	34
35	Rent-Equipment & Vehicles	0	0	0	8,752	0	0	0	0	0	0	0	8,752	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(461)	(210,071)	0	41,582	0	0	0	0	0	0	0	(168,950)	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	(69,438)	0	0	0	0	0	0	0	0	0	(69,438)	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	(69,438)	0	0	0	0	0	0	0	0	0	(69,438)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(57,148)	(580,995)	406,276	41,582	0	0	0	0	0	0	0	(190,285)	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%	\$ (16,295)	\$ (16,295)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(69,438)	(69,438)	3
4	V	19	Adjustment for Related Organization	285,191	Heritage Operations Group, LLC	0.00%		(285,191)	4
5	V								5
6	V	34	Adjustment for Related Organization	411,720	Heritage Manor Real Estate, LLC	0.00%		(411,720)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		56,158	56,158	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		16,677	16,677	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		127,066	127,066	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,748	1,748	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 696,911			\$ 115,916	\$ * (580,995)	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		\$	4,917	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					35	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,528	19
20	V	6	Maintenance					20,574	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					302	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,211	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					18,852	31
32	V	20	Fees, Subscription, Promotions					9,385	32
33	V	21	Clerical & General Office Expenses					287,142	33
34	V	22	Employee Benefits & Payroll Taxes					38,752	34
35	V	23	Inservice Training & Education					1,188	35
36	V	24	Travel and Seminar					6,134	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					16,256	38
39	Total			\$			\$	0	\$ * 406,276 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					26,736	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					287	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,807	20
21	V	35	Rent-Equipment & Vehicles					8,752	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	\$ * 41,582	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 Elgin# 0048132 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	94	\$ 4,917	1
2	2	Food Purchase	Beds	2,571	26	0	0	94	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	94	35	3
4	4	Laundry	Beds	2,571	26	0	0	94	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	94	1,528	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	94	20,574	6
7	7	Other	Beds	2,571	26	0	0	94	0	7
8	9	Medical Director	Beds	2,571	26	0	0	94	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	94	302	9
10	11	Activities	Beds	2,571	26	0	0	94	0	10
11	12	Social Service	Beds	2,571	26	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	94	1,211	12
13	14	Program Transportation	Beds	2,571	26	0	0	94	0	13
14	15	Other	Beds	2,571	26	0	0	94	0	14
15	17	Administrative	Beds	2,571	26	0	0	94	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	94	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	94	18,852	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	94	9,385	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	94	287,142	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	94	38,752	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	94	1,188	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	94	6,134	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	94	16,256	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 406,276	25

Facility Name & ID Number Heritage Health Elgin # 0048132 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 See Pg 8
Street Address _____
City / State / Zip Code _____
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	\$		94	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		94	26,736	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			94		3
4	32	Interest	Beds	2,571	26	7,851		94	287	4
5	33	Real Estate Taxes	Beds	2,571	26			94		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		94	5,807	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		94	8,752	7
8	36	Other	Beds	2,571	26			94		8
9	38	Medically Nec Transportation	Beds	2,571	26			94		9
10	39	Ancillary Service Centers	Beds	2,571	26			94		10
11	40	Barber and Beauty Shops	Beds	2,571	26			94		11
12	41	Coffee and Gift Shops	Beds	2,571	26			94		12
13	42	Other	Beds	2,571	26			94		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	\$		\$ 41,582	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			\$					\$ 16,677	1
2	Bank of America		x	Loan Fee Amortization								1,748	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x	Working Capital								42,681	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 61,106	9
	B. Non-Facility Related*												
10	Interest Income											(461)	10
11													11
12	Allocated Corporate											287	12
13													13
14	TOTAL Non-Facility Related						\$					\$ (174)	14
15	TOTALS (line 9+line14)						\$					\$ 60,932	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$56,158	2
3. Under or (over) accrual (line 2 minus line 1).			\$56,158	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.			\$56,158	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	45,693	8	
	2012	45,145	9	
	2013	41,653	10	
	2014	50,038	11	
	2015		12	
				FOR BHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

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

FACILITY NAME Heritage Health Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0048132

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.

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.)

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

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

A. Square Feet:

30,275

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				\$ 80,000	1
2					2
3	TOTALS			\$ 80,000	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	94				\$ 720,000	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1989 Improvements		1989		180,739					9
10	1990 Improvements		1990		658,346					10
11	1990 Improvements		1990		4,320					11
12	1991 Improvements		1991		52,989					12
13	1992 Improvements		1992		6,777					13
14	1993 Improvements		1993		54,564					14
15	1994 Improvements		1994		81,347					15
16	1995 Improvements		1995		146,394					16
17	Remodel Resident Day Room/Nurses Station		1996		23,749					17
18	Interior Rehab		1997		751					18
19	Electric Water Heater		1997		3,965					19
20	Booster Heater		1997		1,622					20
21	Water Heater and Storage Tank		1998		6,485					21
22										22
23	Water Heater		1999		4,750					23
24	Code Alert System		1999		1,570					24
25	Resident Room Remodel--Material and Labor		1999		2,571					25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33	C/O Allocation					26,736		26,736		33
34	Book Depreciation					107,998		107,998		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 Elgin

#

0048132

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 South Wing Remodel -- Labor / Materials	2000	\$ 14,334	\$		\$	\$	\$	37
38 Door	2000	1,535						38
39 Dry Chemical Extinguisher	2000	1,746						39
40								40
41 Water Heater	2001	4,935						41
42 Valve thermometer	2001	4,520						42
43 A/C Unit	2001	3,319						43
44 Hallway Carpet and Tile Material and Labor	2001	28,843						44
45 Wallpaper	2001	2,390						45
46 Nurse Call System	2001	21,612						46
47								47
48 Hallway and Room Carpet and Tile Material	2002	74,533						48
49 Labor	2002	68,734						49
50 Professional Fees	2002	16,497						50
51 Kitchen Pipe	2002	1,830						51
52 Shower Repairs	2002	5,063						52
53 A/C Unit	2002	5,864						53
54 Bathroom Rehab	2002	750						54
55 Condensor	2002	1,600						55
56 Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57								57
58 Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59 Exterior Door	2003	320						59
60 Parking Lot Sealer	2003	4,469						60
61 Door Security	2003	2,160						61
62 Ductwork	2003	6,628						62
63 compressor	2003	1,195						63
64 Blower Unit	2003	1,784						64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,324,370	\$ 134,734		\$ 134,734	\$	\$	70

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

Facility Name & ID Number Heritage Health Elgin

0048132

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		\$ 2,324,370	\$ 134,734		\$ 134,734	\$	\$	1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7	Fire Alarm	2006	1,714						7
8	Parking Lot	2006	2,344						8
9	Remodel Corridor --paint	2006	4,028						9
10	Water Main	2006	3,250						10
11									11
12	Roof	2007	94,451						12
13	Central Corridor paint, tile	2007	49,685						13
14	Plumbing fixtures	2007	2,400						14
15	Rooftop heat/cool unit	2007	5,565						15
16									16
17	A/C Units	2008	19,600						17
18	4 Ton A/C Unit	2008	2,600						18
19	HVAC Rooftop Unit	2008	11,000						19
20									20
21	Patio	2009	11,693						21
22	Front Entry Doors	2009	13,529						22
23	Front Office Carpet and Window Treatments	2009	3,864						23
24									24
25	Cat5 cable/wire facility	2010	6,607						25
26									26
27	Electric water heater	2011	11,750						27
28	Sign	2011	2,500						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,576,726	\$ 134,734		\$ 134,734	\$	\$	34

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

Facility Name & ID Number Heritage Health Elgin

0048132

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		\$ 2,576,726	\$ 134,734		\$ 134,734	\$	\$	1
2									2
3	Smoke Detector	2012	6,090						3
4	Aiphone	2012	7,030						4
5	Walk in Freezer	2012	5,210						5
6									6
7	Fire Sprinler System	2013	167,700						7
8	Lighting Retrofit	2013	13,876						8
9	New 60 kw Generator	2013	75,234						9
10	Install Door Alarms	2013	5,252						10
11	Fire Alarm Control Panel	2013	12,311						11
12	Parking Lot Replacement	2013	72,770						12
13	Cabling for Wireless Network	2013	11,960						13
14									14
15	Replace main water heater	2016	12,166						15
16	Repalce flooring - North day room	2016	7,026						16
17	Bathroom remodeling - Units 6A, 6B and 29 - remove tubs and	2016	19,779						17
18	replace with showers; added new tile and wall boards								18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,993,130	\$ 134,734		\$ 134,734	\$	\$	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	\$832,854	\$19,068	\$19,068	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$832,854	\$19,068	\$19,068	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,905,984	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$153,802	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$153,802	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$19,549Description:Televisions, Mattresses, Concentrators
(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		5,640		5,640
3	Classroom Wages (a)		7,762		7,762
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 13,402	\$	\$ 13,402
10	SUM OF line 9, col. 1 and 2 (e)	\$ 13,402			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

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	\$		\$ 397,613	\$		\$ 397,613	1
2	Licensed Speech and Language Development Therapist		hrs			27,391			27,391	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			302,877	3,071		305,948	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				384,741		384,741	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					8,123			8,123	13
14	TOTAL			\$		\$ 736,004	\$ 387,812		\$ 1,123,816	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	\$ 1,480	\$	1
2	Cash-Patient Deposits	49,739		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,509,390		3
4	Supply Inventory (priced at)	18,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,549		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(557,910)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,045,748	\$	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)	\$ 1,045,748	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 185,779	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,739		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,339		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,287		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	26,544		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 552,688	\$	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)	\$ 552,688	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 493,060	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,045,748	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 340,147	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 340,147	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	152,913	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)	\$ 152,913	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)	\$ 493,060	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Elgin

0048132

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	\$ 6,047,800	1
2	Discounts and Allowances for all Levels	(1,895,628)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,152,172	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,869,064	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,869,064	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	714,437	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 714,437	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	461	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 461	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)	\$ 6,736,134	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,094,644	31
32	Health Care	2,658,345	32
33	General Administration	1,628,221	33
	B. Capital Expense		
34	Ownership	473,950	34
	C. Ancillary Expense		
35	Special Cost Centers	728,061	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)*	\$ 6,583,221	40
41	Income before Income Taxes (line 30 minus line 40)**	152,913	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 152,913	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	1,877	1,976	\$ 88,971	\$ 45.03	1
2	Assistant Director of Nursing	3,671	3,864	160,559	41.55	2
3	Registered Nurses	14,165	14,911	545,280	36.57	3
4	Licensed Practical Nurses	6,254	6,584	197,283	29.96	4
5	CNAs & Orderlies	54,266	57,122	911,441	15.96	5
6	CNA Trainees	841	885	7,762	8.77	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,591	3,781	77,500	20.50	8
9	Activity Director					9
10	Activity Assistants	6,720	7,074	77,350	10.93	10
11	Social Service Workers	1,809	1,904	42,248	22.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,134	20,142	268,641	13.34	15
16	Dishwashers					16
17	Maintenance Workers	5,391	5,676	119,109	20.98	17
18	Housekeepers	12,302	12,950	148,457	11.46	18
19	Laundry	2,012	2,118	29,363	13.86	19
20	Administrator	1,984	2,088	114,993	55.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,824	12,446	324,525	26.07	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)	145,841	153,521	\$ 3,113,482 *	\$ 20.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,168		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,493		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,192		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,853		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

STATE OF ILLINOIS

Facility Name & ID Number

Heritage Health Elgin

0048132

Report Period Beginning:

01/01/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Linda Hartmann

\$ 114,993

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 114,993

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

\$ 285,190

ADP

Payroll tax processing

1,223

Tango Inc.

ACA compliance

570

McKee Environmental

Phase 1 Review

1,636

Legal adj to Zero

11,465

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 300,084

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 22,739

Unemployment Compensation Insurance

25,308

FICA Taxes

238,181

Employee Health Insurance

191,524

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Benefits

11,093

Central Office Allocation

38,752

TOTAL (agree to Schedule V, line 22, col.8)

\$ 527,597

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

1,553

Health Care Worker Background Check (Indicate # of checks performed)

2,618

PR

15,911

Dues & Subscriptions

6,143

License & Fees

5,091

Central Office Allocation

9,385

Less: Public Relations Expense

(15,911)

Non-allowable advertising

(3,088)

Yellow page advertising ()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 21,702

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

4,147

52

Seminar Expense

3,752

(2,952)

Entertainment Expense ()

TOTAL (agree to Sch. V, line 24, col. 8)

\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Heritage Health Elgin</u>	STATE OF ILLINOIS # <u>0048132</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. \$ 210,391
 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? Yes
 Firm Name: Sulaski & Webb

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

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

Heritage Manor Elgin
HFS ID# 203902154001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>	Schedule V Reference	
Provider Participation Fee - \$1.50	Line 20, Col 3	(51,606)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(158,785)
		<u>(210,391)</u>
Provider Participation Fee	Line 42	<u>210,391</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(384,741)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(8,123)
		<u>(392,864)</u>
Ancillary Service Centers	Line 39	<u>392,864</u>
<u>Reclassification of Leased Equipment</u>		
Dues, Fees Subscriptions and Promotions	Line 20, Col 3	(2,155)
Rent - Equipment & Vehicles	Line 35, Col 3	<u>2,155</u>