

		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: 0048074

Facility Name: Heritage Health Mt Zion

Address: 1225 Woodland Drive Mt Zion 62549
Number City Zip Code

County: Macon

Telephone Number: 217 864-2356 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 Mt Zion

0048074 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	75	Skilled (SNF)	75	27,450	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	75	TOTALS	75	27,450	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	15,212	6,648	2,735	24,595	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,212	6,648	2,735	24,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.60%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 2,735

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	174,252	16,607		190,859		190,859	3,923	194,782			1
2	Food Purchase		188,973		188,973		188,973		188,973			2
3	Housekeeping	62,309	23,252		85,561		85,561	28	85,589			3
4	Laundry	97,814	8,411		106,225		106,225		106,225			4
5	Heat and Other Utilities			110,795	110,795		110,795	1,219	112,014			5
6	Maintenance	66,618	46,289	51,197	164,104		164,104	16,415	180,519			6
7	Other (specify):*											7
8	TOTAL General Services	400,993	283,532	161,992	846,517		846,517	21,585	868,102			8
	B. Health Care and Programs											
9	Medical Director			22,680	22,680		22,680		22,680			9
10	Nursing and Medical Records	1,392,018	130,983	119,993	1,642,994		1,642,994	(22,384)	1,620,610			10
10a	Therapy		494,070	9,189	503,259	(503,072)	187		187			10a
11	Activities	71,552	1,848		73,400		73,400		73,400			11
12	Social Services	47,869		5,651	53,520		53,520		53,520			12
13	CNA Training							966	966			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,511,439	626,901	157,513	2,295,853	(503,072)	1,792,781	(21,418)	1,771,363			16
	C. General Administration											
17	Administrative	92,232			92,232		92,232		92,232			17
18	Directors Fees											18
19	Professional Services			222,816	222,816		222,816	(205,930)	16,886			19
20	Dues, Fees, Subscriptions & Promotions			196,618	196,618	(176,609)	20,009	(1,628)	18,381			20
21	Clerical & General Office Expenses	152,763	17,324	6,997	177,084		177,084	229,103	406,187			21
22	Employee Benefits & Payroll Taxes			385,813	385,813		385,813	23,867	409,680			22
23	Inservice Training & Education			6,619	6,619		6,619	948	7,567			23
24	Travel and Seminar			5,600	5,600		5,600	(601)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,646	37,646		37,646	12,970	50,616			26
27	Other (specify):*			164,335	164,335		164,335	(164,335)				27
28	TOTAL General Administration	244,995	17,324	1,026,444	1,288,763	(176,609)	1,112,154	(105,606)	1,006,548			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,157,427	927,757	1,345,949	4,431,133	(679,681)	3,751,452	(105,439)	3,646,013			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							180,061	180,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,053	34,053		34,053	48,226	82,279			32
33	Real Estate Taxes							64,686	64,686			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,867)	4,633			34
35	Rent-Equipment & Vehicles			7,415	7,415		7,415	6,983	14,398			35
36	Other (specify):*											36
37	TOTAL Ownership			369,968	369,968		369,968	(23,911)	346,057			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			610,636	610,636	503,072	1,113,708	(104,324)	1,009,384			39
40	Barber and Beauty Shops			18,082	18,082		18,082		18,082			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					176,609	176,609		176,609			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			628,718	628,718	679,681	1,308,399	(104,324)	1,204,075			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,157,427	927,757	2,344,635	5,429,819		5,429,819	(233,674)	5,196,145			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	(1,096)			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	(7,052)			18
19	Entertainment	(5,495)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,413)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,335)			24
25	Fund Raising, Advertising and Promotional	(9,116)			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)	\$ (190,507)		\$	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)	(43,167)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,167)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (233,674)		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		(3,413)	19	22
23				23
24		(164,335)	27	24
25		(9,116)	20	25
26				26
27		(7,052)	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	(183,916)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	3,923	0	0	0	0	0	0	0	0	3,923	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	28	0	0	0	0	0	0	0	0	28	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,219	0	0	0	0	0	0	0	0	1,219	5
6	Maintenance	0	0	16,415	0	0	0	0	0	0	0	0	16,415	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	21,585	0	0	0	0	0	0	0	0	21,585	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	(22,625)	241	0	0	0	0	0	0	0	0	(22,384)	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	966	0	0	0	0	0	0	0	0	966	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	(22,625)	1,207	0	0	0	0	0	0	0	0	(21,418)	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	(3,413)	(217,558)	15,041	0	0	0	0	0	0	0	0	(205,930)	19
20	Fees, Subscriptions & Promotions	(9,116)	0	7,488	0	0	0	0	0	0	0	0	(1,628)	20
21	Clerical & General Office Expenses	0	0	229,103	0	0	0	0	0	0	0	0	229,103	21
22	Employee Benefits & Payroll Taxes	(7,052)	0	30,919	0	0	0	0	0	0	0	0	23,867	22
23	Inservice Training & Education	0	0	948	0	0	0	0	0	0	0	0	948	23
24	Travel and Seminar	(5,495)	0	4,894	0	0	0	0	0	0	0	0	(601)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,970	0	0	0	0	0	0	0	0	12,970	26
27	Other (specify):*	(164,335)	0	0	0	0	0	0	0	0	0	0	(164,335)	27
28	TOTAL General Administration	(189,411)	(217,558)	301,363	0	0	0	0	0	0	0	0	(105,606)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(189,411)	(240,183)	324,155	0	0	0	0	0	0	0	0	(105,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	158,729	0	21,332	0	0	0	0	0	0	0	180,061	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,096)	49,093	0	229	0	0	0	0	0	0	0	48,226	32
33	Real Estate Taxes	0	64,686	0	0	0	0	0	0	0	0	0	64,686	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,633	0	0	0	0	0	0	0	(323,867)	34
35	Rent-Equipment & Vehicles	0	0	0	6,983	0	0	0	0	0	0	0	6,983	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,096)	(55,992)	0	33,177	0	0	0	0	0	0	0	(23,911)	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	(104,324)	0	0	0	0	0	0	0	0	0	(104,324)	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	(104,324)	0	0	0	0	0	0	0	0	0	(104,324)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(190,507)	(400,499)	324,155	33,177	0	0	0	0	0	0	0	(233,674)	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%	\$ (22,625)	\$ (22,625)	1	
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2	
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(104,324)	(104,324)	3	
4	V	19 Adjustment for Related Organization	217,558	Heritage Operations Group, LLC	0.00%		(217,558)	4	
5	V							5	
6	V	34 Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC	0.00%		(328,500)	6	
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		64,686	64,686	7	
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,370	46,370	8	
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		158,729	158,729	9	
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,723	2,723	10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 546,058			\$ 145,559	\$ * (400,499)	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		\$	3,923	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					28	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,219	19
20	V	6	Maintenance					16,415	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					241	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					966	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					15,041	31
32	V	20	Fees, Subscription, Promotions					7,488	32
33	V	21	Clerical & General Office Expenses					229,103	33
34	V	22	Employee Benefits & Payroll Taxes					30,919	34
35	V	23	Inservice Training & Education					948	35
36	V	24	Travel and Seminar					4,894	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,970	38
39	Total			\$			\$ 0	\$ * 324,155	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					21,332	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					229	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,633	20
21	V	35	Rent-Equipment & Vehicles					6,983	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	\$ * 33,177	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 Mt Zion# 0048074

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	75	\$ 3,923	1
2	2	Food Purchase	Beds	2,571	26	0	0	75	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	75	28	3
4	4	Laundry	Beds	2,571	26	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	75	1,219	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	75	16,415	6
7	7	Other	Beds	2,571	26	0	0	75	0	7
8	9	Medical Director	Beds	2,571	26	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	75	241	9
10	11	Activities	Beds	2,571	26	0	0	75	0	10
11	12	Social Service	Beds	2,571	26	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	75	966	12
13	14	Program Transportation	Beds	2,571	26	0	0	75	0	13
14	15	Other	Beds	2,571	26	0	0	75	0	14
15	17	Administrative	Beds	2,571	26	0	0	75	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	75	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	75	15,041	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	75	7,488	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	75	229,103	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	75	30,919	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	75	948	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	75	4,894	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	75	12,970	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 324,155	25

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	27	Other	Beds	2,571	26	\$	\$	75	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		75	21,332	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			75		3
4	32	Interest	Beds	2,571	26	7,851		75	229	4
5	33	Real Estate Taxes	Beds	2,571	26			75		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		75	4,633	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		75	6,983	7
8	36	Other	Beds	2,571	26			75		8
9	38	Medically Nec Transportation	Beds	2,571	26			75		9
10	39	Ancillary Service Centers	Beds	2,571	26			75		10
11	40	Barber and Beauty Shops	Beds	2,571	26			75		11
12	41	Coffee and Gift Shops	Beds	2,571	26			75		12
13	42	Other	Beds	2,571	26			75		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	\$		\$ 33,177	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			\$					\$ 46,370	1
2	Bank of America		x	Loan Fee Amortization								2,723	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x	Working Capital								34,053	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 83,146	9
	B. Non-Facility Related*												
10	Interest Income											(1,096)	10
11													11
12	Allocated Corporate											229	12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (867)	14
15	TOTALS (line 9+line14)						\$		\$			\$ 82,279	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	64,6862
3. Under or (over) accrual (line 2 minus line 1).				\$	64,6863
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.				\$	64,6867
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	60,228	8	
		2012	61,050	9	
		2013	61,882	10	
		2014	62,358	11	
		2015	64,686	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

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

FACILITY NAME Heritage Health Mt Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0048074

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

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

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

A. Square Feet: 21,920

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				\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

Facility Name & ID Number Heritage Health Mt Zion

0048074

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	75				\$ 1,076,000	\$		\$		4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Environmental Site Study			1998	1,662					9
10	Sign			1998	1,860					10
11	Air conditioning Unit			1999	5,732					11
12	Air Conditioner			1999	750					12
13	Professional Fees --Remodeling Project			1999	15,922					13
14										14
15	Facility Remodel -- Materials			2000	241,637					15
16	Professional Fees --Remodeling Project			2000	58,519					16
17	Kitchen A/C			2000	990					17
18	Fire Alarm			2000	1,997					18
19	Door Guard System			2000	3,444					19
20										20
21	Smoke Detectors			2001	3,775					21
22	Water Main Break			2001	3,426					22
23	Commercial Disposer			2001	757					23
24	Heat Pump			2001	5,158					24
25	Carpet Extract			2001	1,206					25
26				2001						26
27	Facility Remodel -- Contractor			2001	1,397,646					27
28	Professional Fees --Remodeling Project			2001	45,077					28
29										29
30	Facility Remodel -- Contractor			2002	2,762					30
31	Fire Dampers			2002	2,766					31
32										32
33	C/O Allocation					21,332		21,332		33
34	Book Depreciation					129,635		129,635		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 Mt Zion

0048074

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	Asphalt Sealing	2003	\$ 1,447	\$		\$	\$	\$	37
38	Sprinklers	2003	2,680						38
39	Storm Windows	2003	1,173						39
40									40
41	Water Heater	2004	1,114						41
42	Disposal	2004	871						42
43									43
44	A/C Laundry Room	2005	2,968						44
45									45
46	Sidewalk	2006	4,080						46
47	Parking Lot Sealcoat	2006	2,225						47
48	Dishroom rehab	2006	3,631						48
49	Oxygen storage room rehab	2006	3,858						49
50	Fire Alarm	2006	2,249						50
51									51
52									52
53									53
54									54
55	Storage Garage	2007	23,848						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58									58
59									59
60	Window Replacement	2009	56,034						60
61	HVAC	2009	2,656						61
62	HVAC rooftop	2009	9,250						62
63	Water Heater	2009	7,925						63
64	Parking Lot Sealcoat	2009	31,071						64
65									65
66	Water Heater	2010	16,232						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,056,165	\$ 150,967		\$ 150,967	\$	\$	70

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

Facility Name & ID Number Heritage Health Mt Zion

0048074

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		\$ 3,056,165	\$ 150,967		\$ 150,967	\$	\$	1
2								2
3 Nurse Call & technology system	2011	184,918						3
4 Carpet	2011	9,016						4
5 Medcare lift	2011	8,334						5
6 Asbestos Abatement	2011	11,601						6
7 Heat Exchange	2011	5,637						7
8 Air Handler Unit	2011	4,714						8
9								9
10 Addison air unit	2012	2,940						10
11 Cast Iron Pipe	2012	3,208						11
12 Generator Control	2012	3,362						12
13 Nurse Call & technology system	2012	3,636						13
14								14
15 Flooring - Room 10	2013	3,173						15
16 Lighting Retrofit	2013	2,887						16
17								17
18 Install Replacement Split System - Laundry Room	2014	9,800						18
19 Schematic Design Fees - Facility Renovation Project	2014	8,428						19
20								20
21 Schematic Design Fees - Facility Renovation Project	2015	2,101						21
22 Install (8) six gallon electric water heaters	2015	6,930						22
23 Replace compressor on walk-in freezer	2015	3,843						23
24								24
25 No Improvements made in 2016								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,330,693	\$ 150,967		\$ 150,967	\$	\$	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	\$746,734	\$29,094	\$29,094	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$746,734	\$29,094	\$29,094	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,127,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$180,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$180,061	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.
- ☐ 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☐ NOTerms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$7,415Description:Televisions and Office equipment
- ☐ YES☒ NO
- (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

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

12345678										
	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	\$		\$ 295,831	\$		\$ 295,831	1
2	Licensed Speech and Language Development Therapist		hrs			43,509			43,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			271,296	187		271,483	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				493,883		493,883	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,189			9,189	13
14	TOTAL			\$		\$ 619,825	\$ 494,070		\$ 1,113,895	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 759	\$	1
2	Cash-Patient Deposits	11,023		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,237,020		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,047		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(987,587)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 282,262	\$	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)	\$ 282,262	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 195,247	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,023		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,812		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,410		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	21,482		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 378,974	\$	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)	\$ 378,974	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (96,712)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 282,262	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 117,698	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 117,698	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(214,410)	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)	\$ (214,410)	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)	\$ (96,712)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Mt Zion

0048074

Report Period Beginning: 01/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,493,389	1
2	Discounts and Allowances for all Levels	(2,059,452)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,433,937	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,827,870	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,827,870	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	19,129	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	933,119	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	258	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 952,506	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,096	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,096	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,215,409	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	846,517	31
32	Health Care	2,295,853	32
33	General Administration	1,288,763	33
	B. Capital Expense		
34	Ownership	369,968	34
	C. Ancillary Expense		
35	Special Cost Centers	628,718	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,429,819	40
41	Income before Income Taxes (line 30 minus line 40)**	(214,410)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (214,410)	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	1,699	1,788	\$ 62,846	\$ 35.15	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,919	9,388	281,050	29.94	3
4	Licensed Practical Nurses	13,280	13,980	355,198	25.41	4
5	CNAs & Orderlies	46,467	48,914	643,672	13.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,716	1,806	49,252	27.27	8
9	Activity Director					9
10	Activity Assistants	4,534	4,773	71,552	14.99	10
11	Social Service Workers	1,725	1,816	47,869	26.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,164	14,909	174,252	11.69	15
16	Dishwashers					16
17	Maintenance Workers	3,276	3,448	66,618	19.32	17
18	Housekeepers	5,444	5,732	62,309	10.87	18
19	Laundry	6,450	6,789	97,814	14.41	19
20	Administrator	1,984	2,088	92,232	44.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,069	6,388	152,763	23.91	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)	115,727	121,819	\$ 2,157,427 *	\$ 17.71	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		22,680		36
37	Medical Records Consultant		1,880		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,482		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		5,651		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 34,693		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 27,507		50
51	Licensed Practical Nurses		14,728		51
52	Certified Nurse Assistants/Aides		70,981		52
53	TOTAL (lines 50 - 52)		\$ 113,216		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Heritage Health Mt Zion

0048074

Report Period Beginning:

01/01/16

Ending:

12/31/16

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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	
Rachel Cassella			\$ 92,232	Workers' Compensation Insurance	\$ 27,099	IDPH License Fee	\$	
				Unemployment Compensation Insurance	22,748	Advertising: Employee Recruitment	2,021	
				FICA Taxes	165,043	Health Care Worker Background Check		
				Employee Health Insurance	146,312	(Indicate # of checks performed)	1,289	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
						PR	5,548	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits	17,559	Dues & Subscriptions	5,682	
(List each licensed administrator separately.)			\$ 92,232	Central Office Allocation	30,919	License & Fees	4,802	
B. Administrative - Other						Central Office Allocation	7,488	
Description			Amount			Less: Public Relations Expense	(5,548)	
			\$			Non-allowable advertising	(2,901)	
						Yellow page advertising (	)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 409,680	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,381	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Heritage Operations Group	Mgt services		\$ 217,558					
ADP	Payroll tax processing		1,242					
Tango Inc.	ACA compliance		603				In-State Travel	
								4,396
								0
							Seminar Expense	1,204
								(601)
Legal adj to Zero			3,413				Entertainment Expense (	)
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 222,816	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 Mt Zion</u>	STATE OF ILLINOIS # <u>0048074</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. HCCI

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 7 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ 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. \$ 176,609
 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? Yes Indicate the amount. \$ 1,670

(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 Mt. Zion
HFS ID# 203903622001
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	(41,175)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(135,434)
		<u>(176,609)</u>
		<u>(176,609)</u>
Provider Participation Fee	Line 42	<u>176,609</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(493,883)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(9,189)
		<u>(503,072)</u>
		<u>(503,072)</u>
Ancillary Service Centers	Line 39	<u>503,072</u>