

		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: 0053421

Facility Name: Heritage Health Robinson

Address: 600 E Robinwood Dr Robinson 62454
Number City Zip Code

County: Crawford

Telephone Number: (618) 544-3192 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 2015

Type of Ownership:

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

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

In the event there are further questions about this report, please contact:
Name: Dave Underwood Telephone Number: 309 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid
Preparer

(Signed) _____ (Date) _____
(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 Robinson

0053421 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	67	25,026	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	73	TOTALS	67	25,026	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	11,913	3,988	2,828	18,729	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,913	3,988	2,828	18,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.84%

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 2015

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 2,828

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 Robinson # 0053421 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	152,665	9,140		161,805		161,805	3,505	165,310			1
2	Food Purchase		139,252		139,252		139,252		139,252			2
3	Housekeeping	71,479	19,293		90,772		90,772	25	90,797			3
4	Laundry	28,431	8,247		36,678		36,678		36,678			4
5	Heat and Other Utilities			62,256	62,256		62,256	1,089	63,345			5
6	Maintenance	50,936	27,915	48,896	127,747		127,747	14,664	142,411			6
7	Other (specify):*											7
8	TOTAL General Services	303,511	203,847	111,152	618,510		618,510	19,283	637,793			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,065,521	80,005	15,959	1,161,485		1,161,485	(22,424)	1,139,061			10
10a	Therapy		465,260	17,820	483,080	(482,673)	407		407			10a
11	Activities	38,933	2,163		41,096		41,096		41,096			11
12	Social Services	28,451		3,593	32,044		32,044		32,044			12
13	CNA Training							863	863			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,132,905	547,428	55,372	1,735,705	(482,673)	1,253,032	(21,561)	1,231,471			16
	C. General Administration											
17	Administrative	78,338			78,338		78,338		78,338			17
18	Directors Fees											18
19	Professional Services			186,242	186,242		186,242	(165,491)	20,751			19
20	Dues, Fees, Subscriptions & Promotions			163,980	163,980	(142,380)	21,600	(5,445)	16,155			20
21	Clerical & General Office Expenses	160,713	17,070	5,924	183,707		183,707	204,665	388,372			21
22	Employee Benefits & Payroll Taxes			356,642	356,642		356,642	27,621	384,263			22
23	Inservice Training & Education			4,913	4,913		4,913	847	5,760			23
24	Travel and Seminar			5,651	5,651		5,651	(652)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,039	32,039		32,039	11,587	43,626			26
27	Other (specify):*			49,701	49,701		49,701	(49,701)				27
28	TOTAL General Administration	239,051	17,070	805,092	1,061,213	(142,380)	918,833	23,431	942,264			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,675,467	768,345	971,616	3,415,428	(625,053)	2,790,375	21,153	2,811,528			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							175,929	175,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,203	31,203		31,203	108,405	139,608			32
33	Real Estate Taxes							24,111	24,111			33
34	Rent-Facility & Grounds			319,740	319,740		319,740	(315,601)	4,139			34
35	Rent-Equipment & Vehicles			11,522	11,522		11,522	6,238	17,760			35
36	Other (specify):*											36
37	TOTAL Ownership			362,465	362,465		362,465	(918)	361,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			527,765	527,765	482,673	1,010,438	(103,654)	906,784			39
40	Barber and Beauty Shops			8,812	8,812		8,812		8,812			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					142,380	142,380		142,380			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			536,577	536,577	625,053	1,161,630	(103,654)	1,057,976			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,675,467	768,345	1,870,658	4,314,470		4,314,470	(83,419)	4,231,051			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	(66)			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	(5,024)			19
20	Contributions	(68)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,576)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,633)			24
25	Fund Raising, Advertising and Promotional	(12,134)			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)	\$ (71,501)		\$	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)	(11,918)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (11,918)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (83,419)		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		(68)	27	20
21				21
22		(4,576)	19	22
23				23
24		(49,633)	27	24
25		(12,134)	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	(66,411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Robinson # 0053421 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	3,505	0	0	0	0	0	0	0	0	3,505	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	25	0	0	0	0	0	0	0	0	25	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,089	0	0	0	0	0	0	0	0	1,089	5
6	Maintenance	0	0	14,664	0	0	0	0	0	0	0	0	14,664	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	19,283	0	0	0	0	0	0	0	0	19,283	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	(22,639)	215	0	0	0	0	0	0	0	0	(22,424)	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	863	0	0	0	0	0	0	0	0	863	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	(22,639)	1,078	0	0	0	0	0	0	0	0	(21,561)	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	(4,576)	(174,352)	13,437	0	0	0	0	0	0	0	0	(165,491)	19
20	Fees, Subscriptions & Promotions	(12,134)	0	6,689	0	0	0	0	0	0	0	0	(5,445)	20
21	Clerical & General Office Expenses	0	0	204,665	0	0	0	0	0	0	0	0	204,665	21
22	Employee Benefits & Payroll Taxes	0	0	27,621	0	0	0	0	0	0	0	0	27,621	22
23	Inservice Training & Education	0	0	847	0	0	0	0	0	0	0	0	847	23
24	Travel and Seminar	(5,024)	0	4,372	0	0	0	0	0	0	0	0	(652)	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	11,587	0	0	0	0	0	0	0	0	11,587	26
27	Other (specify):*	(49,701)	0	0	0	0	0	0	0	0	0	0	(49,701)	27
28	TOTAL General Administration	(71,435)	(174,352)	269,218	0	0	0	0	0	0	0	0	23,431	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(71,435)	(196,991)	289,579	0	0	0	0	0	0	0	0	21,153	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Robinson # 0053421 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	156,873	0	19,056	0	0	0	0	0	0	0	175,929	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66)	108,266	0	205	0	0	0	0	0	0	0	108,405	32
33	Real Estate Taxes	0	24,111	0	0	0	0	0	0	0	0	0	24,111	33
34	Rent-Facility & Grounds	0	(319,740)	0	4,139	0	0	0	0	0	0	0	(315,601)	34
35	Rent-Equipment & Vehicles	0	0	0	6,238	0	0	0	0	0	0	0	6,238	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(66)	(30,490)	0	29,638	0	0	0	0	0	0	0	(918)	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	(103,654)	0	0	0	0	0	0	0	0	0	(103,654)	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	(103,654)	0	0	0	0	0	0	0	0	0	(103,654)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(71,501)	(331,135)	289,579	29,638	0	0	0	0	0	0	0	(83,419)	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%	\$ (22,639)	\$ (22,639)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(103,654)	(103,654)	3
4	V	19	Adjustment for Related Organization	174,352	Heritage Operations Group, LLC	0.00%		(174,352)	4
5	V								5
6	V	34	Adjustment for Related Organization	319,740	Heritage Manor Real Estate, LLC	0.00%		(319,740)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		24,111	24,111	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		107,378	107,378	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		156,873	156,873	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		888	888	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 494,092			\$ 162,957	\$ * (331,135)	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		\$	3,505	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					25	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,089	19
20	V	6	Maintenance					14,664	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					215	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					863	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					13,437	31
32	V	20	Fees, Subscription, Promotions					6,689	32
33	V	21	Clerical & General Office Expenses					204,665	33
34	V	22	Employee Benefits & Payroll Taxes					27,621	34
35	V	23	Inservice Training & Education					847	35
36	V	24	Travel and Seminar					4,372	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					11,587	38
39	Total			\$			\$ 0	\$ * 289,579	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					19,056	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					205	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,139	20
21	V	35	Rent-Equipment & Vehicles					6,238	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	\$ * 29,638	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 Robinson# 0053421

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	67	\$ 3,505	1
2	2	Food Purchase	Beds	2,571	26	0	0	67	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	67	25	3
4	4	Laundry	Beds	2,571	26	0	0	67	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	67	1,089	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	67	14,664	6
7	7	Other	Beds	2,571	26	0	0	67	0	7
8	9	Medical Director	Beds	2,571	26	0	0	67	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	67	215	9
10	11	Activities	Beds	2,571	26	0	0	67	0	10
11	12	Social Service	Beds	2,571	26	0	0	67	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	67	863	12
13	14	Program Transportation	Beds	2,571	26	0	0	67	0	13
14	15	Other	Beds	2,571	26	0	0	67	0	14
15	17	Administrative	Beds	2,571	26	0	0	67	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	67	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	67	13,437	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	67	6,689	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	67	204,665	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	67	27,621	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	67	847	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	67	4,372	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	67	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	67	11,587	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 289,579	25

Facility Name & ID Number Heritage Health Robinson # 0053421 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	\$	\$	67	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		67	19,056	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			67		3
4	32	Interest	Beds	2,571	26	7,851		67	205	4
5	33	Real Estate Taxes	Beds	2,571	26			67		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		67	4,139	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		67	6,238	7
8	36	Other	Beds	2,571	26			67		8
9	38	Medically Nec Transportation	Beds	2,571	26			67		9
10	39	Ancillary Service Centers	Beds	2,571	26			67		10
11	40	Barber and Beauty Shops	Beds	2,571	26			67		11
12	41	Coffee and Gift Shops	Beds	2,571	26			67		12
13	42	Other	Beds	2,571	26			67		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	\$		\$ 29,638	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	Morton Community Bank		x	Mortgage			\$				\$	107,378	1	
2	Morton Community Bank		x	Loan Fee Amortization								888	2	
3													3	
4													4	
5													5	
	Working Capital													
6	Bank of America		x									31,203	6	
7													7	
8													8	
9	TOTAL Facility Related						\$		\$			\$	139,469	9
	B. Non-Facility Related*													
10	Interest Income											(66)	10	
11													11	
12	Allocated Corporate											205	12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	139	14
15	TOTALS (line 9+line14)						\$		\$			\$	139,608	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.)

FACILITY NAME Heritage Health Robinson COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0053421

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.

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:

21,869

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				\$ 26,000	1
2					2
3	TOTALS			\$ 26,000	3

Facility Name & ID Number Heritage Health Robinson

0053421

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	67				\$ 1,525,000	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Acquisition of Building Improvements from prior Operator			2001	154,177					9
10										10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291					11
12	Dinning Room/Day Room Addition---Design			2001	50,288					12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670					13
14										14
15	Dinning Room/Day Room Addition---Outside Contractor			2002	66,633					15
16	Dinning Room/Day Room Addition---Design			2002	4,665					16
17	Heating Duct Replacement			2002	12,146					17
18										18
19	Dinning Room/Day Room Addition---Paid by ProCare			2002	200,750					19
20	directly to General Contractor									20
21										21
22	Heat Pump			2003	12,720					22
23	Compressor			2003	1,333					23
24	A/C Unit			2003	2,569					24
25	Water Heater			2003	7,262					25
26	Sprinkler Head Replacements			2003	3,993					26
27	Asphalt Sealing			2003	1,260					27
28	idph			2003	8,618					28
29										29
30	Rewire Resident Rooms			2004	3,250					30
31										31
32										32
33	C/O Allocation					19,056		19,056		33
34	Book Depreciation					118,154		118,154		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 Robinson

0053421

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 Parking Lot Sealer	2005	\$ 1,260	\$		\$	\$	\$	37
38 Doors	2005	660						38
39 A/C compressor	2005	983						39
40 Sidewalk	2005	7,898						40
41 Ansul System	2005	1,990						41
42								42
43 Furnace	2006	4,850						43
44 Roof	2006	7,230						44
45 A/C compressor	2006	1,354						45
46 Water line	2006	1,119						46
47								47
48 A/C	2007	6,406						48
49 Parking Lot	2007	36,176						49
50								50
51 CC TV system	2008	3,397						51
52 Parking Lot	2008	15,919						52
53 Hallway Painting	2008	5,325						53
54 Landscaping	2008	9,896						54
55 Exit Doors	2008	4,138						55
56								56
57								57
58 Furnace	2009	7,443						58
59 Dumpster Pad	2009	3,400						59
60 Parking Lot	2009	2,619						60
61 Door Closers	2009	4,465						61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,355,153	\$ 137,210		\$ 137,210	\$	\$	70

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

Facility Name & ID Number Heritage Health Robinson

0053421

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		\$ 2,355,153	\$ 137,210		\$ 137,210	\$	\$	1
2									2
3	General Conditions & Demolition	2009	73,230						3
4	Carpentry & Millwork	2009	45,270						4
5	Acoustical Ceiling & Flooring	2009	49,176						5
6	Painting	2009	36,800						6
7	Plumbing	2009	10,600						7
8	Electrical	2009	18,430						8
9	Design and layout	2009	13,837						9
10	Project Materials	2009	99,339						10
11	Interior Doors and toilets & related hardware	2009	67,621						11
12	Flooring Central Core	2009	23,320						12
13									13
14	Service sink	2010	5,225						14
15	AHU replacement	2010	4,934						15
16									16
17	Window treatments & tile	2011	4,481						17
18	Walk-in cooler	2011	38,164						18
19									19
20	Water Heater	2012	14,802						20
21									21
22	Replacement Chassis - 2 SC Units	2013	2,841						22
23	New Exterior Sign	2013	7,014						23
24	Condensing Unit - Kitchen	2013	3,030						24
25	HVAC Unit - Laundry	2013	3,575						25
26	Window Replacement and Corridor Flooring/Painting	2013	127,782						26
27									27
28	Cabling and Electric - Wireless Network	2014	10,819						28
29	Install Exterior Door	2014	2,551						29
30	Ductless Split System Installation	2014	7,329						30
31	Install New Fire Alarm System	2014	5,250						31
32	Roof Replacement	2014	35,090						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,065,663	\$ 137,210		\$ 137,210	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,065,663	\$ 137,210		\$ 137,210	\$	\$	1
2								2
3 Install 5 ton AC condenser	2015	6,200						3
4								4
5 No 2016 improvements								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,071,863	\$ 137,210		\$ 137,210	\$	\$	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	\$860,365	\$38,719	\$38,719	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$860,365	\$38,719	\$38,719	\$		\$	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)	\$3,958,228	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$175,929	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$175,929	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☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

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

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

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$11,522 Description: Televisions and office machines
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	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)	\$			

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	\$		\$ 233,648	\$		\$ 233,648	1
2	Licensed Speech and Language Development Therapist		hrs			53,470			53,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			240,647	407		241,054	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				464,853		464,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,820			17,820	13
14	TOTAL			\$		\$ 545,585	\$ 465,260		\$ 1,010,845	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	\$ 27,602	\$	1
2	Cash-Patient Deposits	6,505		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,160,943		3
4	Supply Inventory (priced at FIFO)	18,809		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,861		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,138,211)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 95,509	\$	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)	\$ 95,509	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 149,022	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,505		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,838		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,614		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	16,122		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 327,101	\$	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)	\$ 327,101	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (231,592)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 95,509	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 862,049	1
2	Restatements (describe):		2
3	Reclass expired joint venture investment	(889,085)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (27,036)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,556)	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)	\$ (204,556)	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)	\$ (231,592)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Robinson

0053421

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	\$ 3,544,912	1
2	Discounts and Allowances for all Levels	(2,141,483)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,403,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,833,095	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,833,095	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	7,770	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	862,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,844	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 873,324	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66	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)	\$ 4,109,914	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	618,510	31
32	Health Care	1,735,705	32
33	General Administration	1,061,213	33
	B. Capital Expense		
34	Ownership	362,465	34
	C. Ancillary Expense		
35	Special Cost Centers	536,577	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)*	\$ 4,314,470	40
41	Income before Income Taxes (line 30 minus line 40)**	(204,556)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (204,556)	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	1,540	1,621	\$ 54,247	\$ 33.47	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	11,176	11,764	316,392	26.89	3
4	Licensed Practical Nurses	5,401	5,685	115,126	20.25	4
5	CNAs & Orderlies	40,371	42,496	519,384	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,763	2,908	60,372	20.76	8
9	Activity Director					9
10	Activity Assistants	3,169	3,336	38,933	11.67	10
11	Social Service Workers	1,930	2,032	28,451	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,133	15,930	152,665	9.58	15
16	Dishwashers					16
17	Maintenance Workers	3,073	3,235	50,936	15.75	17
18	Housekeepers	6,935	7,300	71,479	9.79	18
19	Laundry	3,058	3,219	28,431	8.83	19
20	Administrator	1,984	2,088	78,338	37.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,790	7,147	160,713	22.49	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)	103,323	108,761	\$ 1,675,467 *	\$ 15.41	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		18,000		36
37	Medical Records Consultant		359		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,547		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		3,593		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,499		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		11,946		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		\$ 11,946		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHeritage Health Robinson# 0053421Report Period Beginning:01/01/16Ending:12/31/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roxann Summers			\$ 78,338
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,338

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	\$ 174,352
ADP	Payroll tax processing	1,233
Tango Inc	ACA compliance	476
Legal adj to Zero		10,181
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 186,242

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 65,586
Unemployment Compensation Insurance	36,592
FICA Taxes	128,173
Employee Health Insurance	99,268
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	27,023
Central Office Allocation	27,621
TOTAL (agree to Schedule V, line 22, col.8)	

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	3,286
Health Care Worker Background Check (Indicate # of checks performed)	1,965
PR	3,131
Dues & Subscriptions	4,050
License & Fees	2,178
Central Office Allocation	6,689
Less: Public Relations Expense	(3,131)
Non-allowable advertising	(2,013)
Yellow page advertising (	)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	5,406
	0
Seminar Expense	245
	(652)
Entertainment Expense (	)
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Heritage Health Robinson</u>	STATE OF ILLINOIS # <u>0053421</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 142,380
 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. \$ 1,785

(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 Robinson
HFS ID# 472140069001
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	(37,539)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(104,841)
		<u>(142,380)</u>
Provider Participation Fee	Line 42	<u>142,380</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(464,853)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(17,820)
		<u>(482,673)</u>
Ancillary Service Centers	Line 39	<u>482,673</u>