

		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: 0041699 Facility Name: Heritage Health Springfield Address: 900 North Rutledge Springfield 62702 Number City Zip Code County: Sangamon Telephone Number: (217) 789-0930 Fax # () HFS ID Number: Date of Initial License for Current Owners: 1996 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
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Facility Name & ID Number Heritage Health Springfield

0041699 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	<u>178</u>	Skilled (SNF)	<u>178</u>	<u>65,148</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>178</u>	TOTALS	<u>178</u>	<u>65,148</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>28,535</u>	<u>8,625</u>	<u>7,669</u>	<u>44,829</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,535</u>	<u>8,625</u>	<u>7,669</u>	<u>44,829</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.81%

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 1996

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 7,669

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 Springfield # 0041699 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	348,581	30,603		379,184		379,184	9,311	388,495			1
2	Food Purchase		357,550		357,550		357,550		357,550			2
3	Housekeeping	221,397	61,999		283,396		283,396	67	283,463			3
4	Laundry	109,113	17,205		126,318		126,318		126,318			4
5	Heat and Other Utilities			195,203	195,203		195,203	2,893	198,096			5
6	Maintenance	155,601	93,840	157,330	406,771		406,771	38,959	445,730			6
7	Other (specify):*											7
8	TOTAL General Services	834,692	561,197	352,533	1,748,422		1,748,422	51,230	1,799,652			8
	B. Health Care and Programs											
9	Medical Director			40,600	40,600		40,600		40,600			9
10	Nursing and Medical Records	3,056,375	284,651	154,845	3,495,871		3,495,871	(41,461)	3,454,410			10
10a	Therapy		1,617,581	32,295	1,649,876	(1,644,314)	5,562		5,562			10a
11	Activities	93,919	1,255		95,174		95,174		95,174			11
12	Social Services	64,238		3,498	67,736		67,736		67,736			12
13	CNA Training							2,294	2,294			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,214,532	1,903,487	231,238	5,349,257	(1,644,314)	3,704,943	(39,167)	3,665,776			16
	C. General Administration											
17	Administrative	104,167			104,167		104,167		104,167			17
18	Directors Fees											18
19	Professional Services			458,319	458,319		458,319	(395,023)	63,296			19
20	Dues, Fees, Subscriptions & Promotions			380,034	380,034	(326,792)	53,242	1,931	55,173			20
21	Clerical & General Office Expenses	468,250	43,276	55,727	567,253		567,253	543,737	1,110,990			21
22	Employee Benefits & Payroll Taxes			872,537	872,537		872,537	73,381	945,918			22
23	Inservice Training & Education			2,777	2,777		2,777	2,249	5,026			23
24	Travel and Seminar			3,693	3,693		3,693	1,306	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			109,611	109,611		109,611	30,783	140,394			26
27	Other (specify):* Lost resident items			116,713	116,713		116,713	(114,768)	1,945			27
28	TOTAL General Administration	572,417	43,276	1,999,411	2,615,104	(326,792)	2,288,312	143,596	2,431,908			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,621,641	2,507,960	2,583,182	9,712,783	(1,971,106)	7,741,677	155,659	7,897,336			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			310,885	310,885		310,885	50,627	361,512			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,946	60,946		60,946	(12,320)	48,626			32
33	Real Estate Taxes			123,970	123,970		123,970		123,970			33
34	Rent-Facility & Grounds							10,996	10,996			34
35	Rent-Equipment & Vehicles			34,011	34,011		34,011	16,573	50,584			35
36	Other (specify):*											36
37	TOTAL Ownership			529,812	529,812		529,812	65,876	595,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,384,212	1,384,212	1,644,314	3,028,526	(634,626)	2,393,900			39
40	Barber and Beauty Shops			12,702	12,702		12,702		12,702			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					326,792	326,792		326,792			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,396,914	1,396,914	1,971,106	3,368,020	(634,626)	2,733,394			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,621,641	2,507,960	4,509,908	11,639,509		11,639,509	(413,091)	11,226,418			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	(12,864)			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	(10,310)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,005)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,768)			24
25	Fund Raising, Advertising and Promotional	(15,840)			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)	\$ (179,787)		\$	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)	(233,304)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (233,304)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (413,091)		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		(26,005)	19	22
23				23
24		(114,768)	27	24
25		(15,840)	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	(156,613)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Springfield # 0041699 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	9,311	0	0	0	0	0	0	0	0	9,311	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	67	0	0	0	0	0	0	0	0	67	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,893	0	0	0	0	0	0	0	0	2,893	5
6	Maintenance	0	0	38,959	0	0	0	0	0	0	0	0	38,959	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	51,230	0	0	0	0	0	0	0	0	51,230	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	(42,032)	571	0	0	0	0	0	0	0	0	(41,461)	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	2,294	0	0	0	0	0	0	0	0	2,294	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	(42,032)	2,865	0	0	0	0	0	0	0	0	(39,167)	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	(26,005)	(404,716)	35,698	0	0	0	0	0	0	0	0	(395,023)	19
20	Fees, Subscriptions & Promotions	(15,840)	0	17,771	0	0	0	0	0	0	0	0	1,931	20
21	Clerical & General Office Expenses	0	0	543,737	0	0	0	0	0	0	0	0	543,737	21
22	Employee Benefits & Payroll Taxes	0	0	73,381	0	0	0	0	0	0	0	0	73,381	22
23	Inservice Training & Education	0	0	2,249	0	0	0	0	0	0	0	0	2,249	23
24	Travel and Seminar	(10,310)	0	11,616	0	0	0	0	0	0	0	0	1,306	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	30,783	0	0	0	0	0	0	0	0	30,783	26
27	Other (specify):*	(114,768)	0	0	0	0	0	0	0	0	0	0	(114,768)	27
28	TOTAL General Administration	(166,923)	(404,716)	715,235	0	0	0	0	0	0	0	0	143,596	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(166,923)	(446,748)	769,330	0	0	0	0	0	0	0	0	155,659	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Springfield # 0041699 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	0	0	50,627	0	0	0	0	0	0	0	50,627	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,864)	0	0	544	0	0	0	0	0	0	0	(12,320)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	10,996	0	0	0	0	0	0	0	10,996	34
35	Rent-Equipment & Vehicles	0	0	0	16,573	0	0	0	0	0	0	0	16,573	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,864)	0	0	78,740	0	0	0	0	0	0	0	65,876	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	(634,626)	0	0	0	0	0	0	0	0	0	(634,626)	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	(634,626)	0	0	0	0	0	0	0	0	0	(634,626)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(179,787)	(1,081,374)	769,330	78,740	0	0	0	0	0	0	0	(413,091)	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.	50	Attachment-See Following Page		Heritage Operations G	Bloomington	Mgmt Svcs
Memorial Health Ventures	50			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%	\$ (42,032)	\$ (42,032)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(634,626)	(634,626)	3
4	V	19	Adjustment for Related Organization	404,716	Heritage Operations Group, LLC	0.00%		(404,716)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 404,716			\$ (676,658)	\$ * (1,081,374)	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		\$	\$ 9,311	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					67	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					2,893	19
20	V	6	Maintenance					38,959	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					571	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					2,294	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					35,698	31
32	V	20	Fees, Subscription, Promotions					17,771	32
33	V	21	Clerical & General Office Expenses					543,737	33
34	V	22	Employee Benefits & Payroll Taxes					73,381	34
35	V	23	Inservice Training & Education					2,249	35
36	V	24	Travel and Seminar					11,616	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					30,783	38
39	Total			\$			\$ 0	\$ * 769,330	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					50,627	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					544	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					10,996	20
21	V	35	Rent-Equipment & Vehicles					16,573	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	\$ * 78,740	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.			50.00					\$		1
2	Memorial Health Ventures			50.00							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 Springfield# 0041699

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	178	\$ 9,311	1
2	2	Food Purchase	Beds	2,571	26	0	0	178	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	178	67	3
4	4	Laundry	Beds	2,571	26	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	178	2,893	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	178	38,959	6
7	7	Other	Beds	2,571	26	0	0	178	0	7
8	9	Medical Director	Beds	2,571	26	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	178	571	9
10	11	Activities	Beds	2,571	26	0	0	178	0	10
11	12	Social Service	Beds	2,571	26	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	178	2,294	12
13	14	Program Transportation	Beds	2,571	26	0	0	178	0	13
14	15	Other	Beds	2,571	26	0	0	178	0	14
15	17	Administrative	Beds	2,571	26	0	0	178	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	178	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	178	35,698	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	178	17,771	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	178	543,737	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	178	73,381	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	178	2,249	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	178	11,616	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	178	30,783	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 769,330	25

Facility Name & ID Number Heritage Health Springfield # 0041699 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Heritage Operations Group
Street Address Box 3188
City / State / Zip Code Bloomington, IL 61701
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	\$	\$	178	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		178	50,627	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			178		3
4	32	Interest	Beds	2,571	26	7,851		178	544	4
5	33	Real Estate Taxes	Beds	2,571	26			178		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		178	10,996	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		178	16,573	7
8	36	Other	Beds	2,571	26			178		8
9	38	Medically Nec Transportation	Beds	2,571	26			178		9
10	39	Ancillary Service Centers	Beds	2,571	26			178		10
11	40	Barber and Beauty Shops	Beds	2,571	26			178		11
12	41	Coffee and Gift Shops	Beds	2,571	26			178		12
13	42	Other	Beds	2,571	26			178		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	\$		\$ 78,740	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 Springfield		x	Mortgage			\$	971,323			\$	60,946	1
2	Bank of Springfield		x	Construction				5,184,187					2
3													3
4													4
5													5
	Working Capital												
6	Bank of Springfield		x	Line of Credit				1,175,000					6
7													7
8													8
9	TOTAL Facility Related						\$	7,330,510			\$	60,946	9
	B. Non-Facility Related*												
10	Interest Income										(12,864)		10
11													11
12	Allocated Corporate										544		12
13													13
14	TOTAL Non-Facility Related						\$				\$	(12,320)	14
15	TOTALS (line 9+line14)						\$	7,330,510			\$	48,626	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

[illegible]

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 Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

B. Real Estate Tax Cost Allocations

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

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

Page 10A

A. Square Feet: 64,520

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4

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				\$ 630,000	1
2					2
3	TOTALS			\$ 630,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	178				\$ 1,900,000	\$		\$		4
5					1,648,258					5
6										6
7										7
8										8
	Improvement Type**									
9	1985 Improvements		1985		26,076					9
10	1986 Improvements		1986		216,545					10
11	1987 Improvements		1987		593,121					11
12	1988 Improvements		1988		29,321					12
13	1989 Improvements		1989		1,095					13
14	1990 Improvements		1990		939					14
15	1991 Improvements		1991		32,022					15
16	1992 Improvements		1992		32,593					16
17	1993 Improvements		1993		105,986					17
18	1994 Improvements		1994		59,542					18
19	1995 Improvements		1995		36,126					19
20	Laundry Chute		1996		4,926					20
21	Door Alarm		1996		8,533					21
22	Garbage Disposal		1996		1,113					22
23	Elevator		1996		11,439					23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33	C/O Allocation					50,627		50,627		33
34	Book Depreciation					268,334		268,334		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 Springfield

0041699

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 Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$	37
38 Fire Dampers	1997	510						38
39 Computer Cabling	1997	14,518						39
40 Rehab Therapy Room	1997	7,391						40
41 Air Conditioner--Chiller	1997	47,954						41
42 Remodel First Floor	1997	27,570						42
43								43
44 Landscape	1998	2,410						44
45 Vent Work	1998	7,018						45
46 Asphalt Ramp	1998	850						46
47 Room Remodel	1998	1,142						47
48								48
49 Code Alert	1999	7,829						49
50 Wall Paper	1999	704						50
51 Remodel Office Interior	1999	1,248						51
52 Elevator Repair	1999	2,697						52
53 Carpet	1999	1,097						53
54								54
55 Shed Yardmate	2000	522						55
56 A/C Rooftop Unit	2000	2,937						56
57 Sewerline Repair	2000	1,482						57
58								58
59 Facility Renovation--Materials	2001	745,911						59
60 Facility Renovation--Labor	2001	1,463						60
61 Facility Renovation--Interior Design	2001	69,313						61
62 Fire Alarm System	2001	8,718						62
63 Sewer Line Repair	2001	1,787						63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,668,973	\$ 318,961		\$ 318,961	\$	\$	70

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

Facility Name & ID Number Heritage Health Springfield

0041699

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		\$ 5,668,973	\$ 318,961		\$ 318,961	\$	\$	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11									11
12	Door Replacement	2003	1,216						12
13									13
14									14
15	Shower Room Remodel	2003	14,285						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	36,919						19
20	Elevator Repair	2004	74,457						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24	Controller board	2005	2,460						24
25	Wall Railing	2005	2,837						25
26	A/C Protection	2005	1,318						26
27	Compressor	2005	10,800						27
28	Chiller	2005	2,305						28
29	Rooftop Compressor	2005	4,676						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,050,204	\$ 318,961		\$ 318,961	\$	\$	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		\$ 6,050,204	\$ 318,961		\$ 318,961			1
2 Sprinkler system	2006	250,656						2
3 Door Alarm	2006	2,940						3
4 Stair Treads	2006	12,497						4
5 Roof	2006	2,219						5
6 Fire door	2006	6,154						6
7								7
8 HVAC Controls								8
9	2007	12,375						9
10 Sprinkler system	2007							10
11 Circulating pump	2007	12,140						11
12	2007	2,693						12
13 Walk-in freezer	2007							13
14 Fire Alarm	2007	24,013						14
15 Exit Lighting	2007							15
16	2007							16
17 HVAC								17
18	2007	18,080						18
19 Window treatments	2007							19
20	2007	3,431						20
21 Beauty Shop sink, vanity, painting								21
22	2008	1,597						22
23								23
24 HVAC								24
25 Elevator	2009	11,480						25
26 Boiler	2009	53,743						26
27 Asphalt	2009	2,914						27
28	2009	9,138						28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,476,274	\$ 318,961		\$ 318,961			34

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

Facility Name & ID Number Heritage Health Springfield

0041699

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 12C, Carried Forward		\$ 6,476,274	\$ 318,961		\$ 318,961	\$	\$	1
2								2
3 Elevator	2010	71,294						3
4 Water storage tank	2010	16,211						4
5 paging system	2010	2,642						5
6 water heater	2010	13,740						6
7 dinning room window	2010	49,757						7
8 fire rated metal	2010	3,921						8
9 Aggregate column	2010	34,550						9
10 boiler	2010	3,255						10
11								11
12 100 gallon water heater	2011	8,958						12
13 Chiller	2011	11,556						13
14 Door & Installation	2011	4,361						14
15 Chiller Fan	2011	3,792						15
16 Smoke detector	2011	3,935						16
17 Sign	2011	3,250						17
18								18
19 Lighting upgrade	2012	17,773						19
20 Nurse Call	2012	5,107						20
21								21
22 Nurse Call System Install- Second Floor	2013	13,536						22
23 Extended Care Wing ALC Controls Installation	2013	25,930						23
24 Fire Alarm CPU Replacement	2013	2,761						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)		\$ 6,772,603	\$ 318,961		\$ 318,961	\$	\$	34

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

Facility Name & ID Number Heritage Health Springfield

0041699

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 12D, Carried Forward		\$ 6,772,603	\$ 318,961		\$ 318,961	\$	\$	1
2 Water Pipe Modification	2014	3,598						2
3 Exhaust Fan Replacement	2014	17,340						3
4 Landscaping - Memorial Gardens	2014	15,385						4
5 Hot Water Heater Replacement	2014	3,565						5
6 Gate Valve Replacement-Boiler	2014	2,928						6
7 Replace Existing Roof System	2014	293,339						7
8 Planning for 2015 Remodeling Project	2014							8
9 Architect Planning Fee								9
10 Furniture and Fixtures Design Fees								10
11 State Review of Plans								11
12								12
13 Replace boilers	2015	11,125						13
14 Install steel covering on kitchen hood	2015	3,494						14
15 Replace fire alarm control panel	2015	23,965						15
16								16
17 No Building Improvements added in 2016 -\$ 9 million Remodeling Project will be completed in 2017 and costs reported upon completion								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)		\$ 7,147,342	\$ 318,961		\$ 318,961	\$	\$	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	\$1,784,262	\$42,551	\$42,551	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,784,262	\$42,551	\$42,551	\$		\$	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		2008 Ford Van	2008	\$38,949	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$38,949	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	9,600,553
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	361,512
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	361,512
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Renovation of entire	\$6,513,296
93	facility - 4 floors	
94		
95		\$6,513,296

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$34,011Description:Oxygen cylinders and televisions

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2		3	4	5	6	7	8				
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	768,235			\$	768,235	1		
2	Licensed Speech and Language Development Therapist		hrs				98,652				98,652	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist		hrs				517,325	5,562			522,887	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					1,612,019			1,612,019	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
	Academic Education		hrs									11		
12	Other (specify):											12		
13	Other (specify):						32,295				32,295	13		
14	TOTAL				\$		\$	1,416,507	\$	1,617,581		\$	3,034,088	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	\$ 189,092	\$	1
2	Cash-Patient Deposits	18,819		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,462,339		3
4	Supply Inventory (priced at)	59,293		4
5	Short-Term Investments			5
6	Prepaid Insurance	40,184		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	88,458		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,858,185	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	7,248,885		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,774,887		16
17	Accumulated Depreciation (book methods)	(6,776,834)		17
18	Deferred Charges	1,668,582		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	6,513,296		22
23	Other(specify): Investment in Regency	4,775,018		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,833,834	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,692,019	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 866,303	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,819		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,455		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	128,152		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	37,300		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,055,029	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	7,330,510		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)	\$ 7,330,510	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,385,539	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,306,480	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,692,019	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,241,036	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,241,036	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	65,444	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)	\$ 65,444	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)	\$ 11,306,480	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Springfield

0041699

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	\$ 10,330,715	1
2	Discounts and Allowances for all Levels	(6,582,179)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,748,536	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,904,897	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,904,897	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	1,092	12
13	Barber and Beauty Care	12,541	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,060,430	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(35,407)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,038,656	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,864	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,864	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)	\$ 11,704,953	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,748,422	31
32	Health Care	5,349,257	32
33	General Administration	2,615,104	33
	B. Capital Expense		
34	Ownership	529,812	34
	C. Ancillary Expense		
35	Special Cost Centers	1,396,914	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)*	\$ 11,639,509	40
41	Income before Income Taxes (line 30 minus line 40)**	65,444	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 65,444	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	1,824	1,920	\$ 75,089	\$ 39.11	1
2	Assistant Director of Nursing	4,955	5,216	140,936	27.02	2
3	Registered Nurses	10,132	10,665	330,268	30.97	3
4	Licensed Practical Nurses	36,671	38,601	917,010	23.76	4
5	CNAs & Orderlies	97,655	102,795	1,546,430	15.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,934	3,088	46,642	15.10	8
9	Activity Director					9
10	Activity Assistants	7,564	7,962	93,919	11.80	10
11	Social Service Workers	3,581	3,769	64,238	17.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,596	31,154	348,581	11.19	15
16	Dishwashers					16
17	Maintenance Workers	9,422	9,918	155,601	15.69	17
18	Housekeepers	18,445	19,416	221,397	11.40	18
19	Laundry	9,004	9,478	109,113	11.51	19
20	Administrator	1,984	2,088	104,167	49.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,509	20,536	468,250	22.80	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)	253,276	266,606	\$ 4,621,641 *	\$ 17.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		40,600		36
37	Medical Records Consultant		930		37
38	Nurse Consultant				38
39	Pharmacist Consultant		27,600		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		3,498		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 72,628		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		80,437		51
52	Certified Nurse Assistants/Aides		45,878		52
53	TOTAL (lines 50 - 52)		\$ 126,315		53

Facility Name & ID Number <u>Heritage Health Springfield</u>	STATE OF ILLINOIS # <u>0041699</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? Yes If YES, what is the capacity? 123

(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. \$ 326,792
 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. \$ 2,284

(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 Springfield
HFS ID# 371359387001
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	(97,722)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(229,070)
		<u>(326,792)</u>
Provider Participation Fee	Line 42	<u>326,792</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(1,612,019)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(32,295)
		<u>(1,644,314)</u>
Ancillary Service Centers	Line 39	<u>1,644,314</u>