

		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: 0048876

Facility Name: Heritage Health Staunton

Address: 215 W Pennsylvania Staunton 62088
Number City Zip Code

County: Macoupin

Telephone Number: (618) 635-5577 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

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

x PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
x Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID NumberHeritage Health Staunton

#0048876Report Period Beginning:01/01/16Ending: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 beds3/25/16

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	99	Skilled (SNF)	90	33,696	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	99	TOTALS	90	33,696	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	11,453	9,348	2,535	23,336	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,453	9,348	2,535	23,336	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)69.25%

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?YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YESNOX

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

J. Was the facility purchased or leased after January 1, 1978?YESDateNONOX

K. Was the facility certified for Medicare during the reporting year?YESXNONOXIf YES, enter number of beds certifiedand days of care provided2,535

Medicare IntermediaryWPS

IV. ACCOUNTING BASIS

ACCRUALXMODIFIEDCASH* CASH*

Is your fiscal year identical to your tax year?YESXNONO

Tax Year:Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Health Staunton # 0048876 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	165,190	8,367		173,557		173,557	4,708	178,265			1
2	Food Purchase		145,616		145,616		145,616		145,616			2
3	Housekeeping	111,614	24,259		135,873		135,873	34	135,907			3
4	Laundry	38,942	13,198		52,140		52,140		52,140			4
5	Heat and Other Utilities			91,761	91,761		91,761	1,463	93,224			5
6	Maintenance	51,121	60,494	51,528	163,143		163,143	19,698	182,841			6
7	Other (specify):*											7
8	TOTAL General Services	366,867	251,934	143,289	762,090		762,090	25,903	787,993			8
	B. Health Care and Programs											
9	Medical Director			21,025	21,025		21,025		21,025			9
10	Nursing and Medical Records	1,314,721	87,114	107,659	1,509,494		1,509,494	(14,678)	1,494,816			10
10a	Therapy		423,119	14,248	437,367	(436,712)	655		655			10a
11	Activities	47,936	6,113		54,049		54,049		54,049			11
12	Social Services	39,480		2,216	41,696		41,696		41,696			12
13	CNA Training	4,965	2,070		7,035		7,035	1,160	8,195			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,407,102	518,416	145,148	2,070,666	(436,712)	1,633,954	(13,518)	1,620,436			16
	C. General Administration											
17	Administrative	90,780			90,780		90,780		90,780			17
18	Directors Fees											18
19	Professional Services			241,881	241,881		241,881	(218,612)	23,269			19
20	Dues, Fees, Subscriptions & Promotions			208,508	208,508	(181,425)	27,083	(3,907)	23,176			20
21	Clerical & General Office Expenses	97,309	17,161	7,840	122,310		122,310	274,923	397,233			21
22	Employee Benefits & Payroll Taxes			365,201	365,201		365,201	37,103	402,304			22
23	Inservice Training & Education			5,608	5,608		5,608	1,137	6,745			23
24	Travel and Seminar			3,500	3,500		3,500	1,499	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,743	42,743		42,743	15,564	58,307			26
27	Other (specify):*			57,916	57,916		57,916	(57,916)				27
28	TOTAL General Administration	188,089	17,161	933,197	1,138,447	(181,425)	957,022	49,791	1,006,813			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,962,058	787,511	1,221,634	3,971,203	(618,137)	3,353,066	62,176	3,415,242			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							181,749	181,749			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,038	42,038		42,038	147,681	189,719			32
33	Real Estate Taxes							32,767	32,767			33
34	Rent-Facility & Grounds			433,620	433,620		433,620	(428,060)	5,560			34
35	Rent-Equipment & Vehicles			10,622	10,622		10,622	8,380	19,002			35
36	Other (specify):*											36
37	TOTAL Ownership			486,280	486,280		486,280	(57,483)	428,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			465,745	465,745	436,712	902,457	(85,600)	816,857			39
40	Barber and Beauty Shops		355	14,070	14,425		14,425		14,425			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					181,425	181,425		181,425			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		355	479,815	480,170	618,137	1,098,307	(85,600)	1,012,707			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,962,058	787,866	2,187,729	4,937,653		4,937,653	(80,907)	4,856,746			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	(110)			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	(4,374)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,364)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,916)			24
25	Fund Raising, Advertising and Promotional	(12,892)			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)	\$ (101,656)		\$	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)	20,749		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,749		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (80,907)		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		(26,364)	19	22
23				23
24		(57,916)	27	24
25		(12,892)	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	(97,172)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Staunton # 0048876 Report Period Beginning: 01/01/16 Ending: 12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,708	0	0	0	0	0	0	0	0	4,708	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	34	0	0	0	0	0	0	0	0	34	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,463	0	0	0	0	0	0	0	0	1,463	5
6	Maintenance	0	0	19,698	0	0	0	0	0	0	0	0	19,698	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	25,903	0	0	0	0	0	0	0	0	25,903	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	(14,967)	289	0	0	0	0	0	0	0	0	(14,678)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,160	0	0	0	0	0	0	0	0	1,160	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	(14,967)	1,449	0	0	0	0	0	0	0	0	(13,518)	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	(26,364)	(210,298)	18,050	0	0	0	0	0	0	0	0	(218,612)	19
20	Fees, Subscriptions & Promotions	(12,892)	0	8,985	0	0	0	0	0	0	0	0	(3,907)	20
21	Clerical & General Office Expenses	0	0	274,923	0	0	0	0	0	0	0	0	274,923	21
22	Employee Benefits & Payroll Taxes	0	0	37,103	0	0	0	0	0	0	0	0	37,103	22
23	Inservice Training & Education	0	0	1,137	0	0	0	0	0	0	0	0	1,137	23
24	Travel and Seminar	(4,374)	0	5,873	0	0	0	0	0	0	0	0	1,499	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	15,564	0	0	0	0	0	0	0	0	15,564	26
27	Other (specify):*	(57,916)	0	0	0	0	0	0	0	0	0	0	(57,916)	27
28	TOTAL General Administration	(101,546)	(210,298)	361,635	0	0	0	0	0	0	0	0	49,791	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(101,546)	(225,265)	388,987	0	0	0	0	0	0	0	0	62,176	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Staunton # 0048876 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	156,151	0	25,598	0	0	0	0	0	0	0	181,749	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(110)	147,516	0	275	0	0	0	0	0	0	0	147,681	32
33	Real Estate Taxes	0	32,767	0	0	0	0	0	0	0	0	0	32,767	33
34	Rent-Facility & Grounds	0	(433,620)	0	5,560	0	0	0	0	0	0	0	(428,060)	34
35	Rent-Equipment & Vehicles	0	0	0	8,380	0	0	0	0	0	0	0	8,380	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(110)	(97,186)	0	39,813	0	0	0	0	0	0	0	(57,483)	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	(85,600)	0	0	0	0	0	0	0	0	0	(85,600)	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	(85,600)	0	0	0	0	0	0	0	0	0	(85,600)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(101,656)	(408,051)	388,987	39,813	0	0	0	0	0	0	0	(80,907)	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%	\$ (14,967)	\$ (14,967)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(85,600)	(85,600)	3
4	V	19	Adjustment for Related Organization	210,298	Heritage Operations Group, LLC	0.00%		(210,298)	4
5	V								5
6	V	34	Adjustment for Related Organization	433,620	Heritage Manor Real Estate, LLC	0.00%		(433,620)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		32,767	32,767	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		141,603	141,603	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		156,151	156,151	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,913	5,913	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 643,918			\$ 235,867	\$ * (408,051)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Operations Group LLC		\$	\$ 4,708	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					34	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,463	19
20	V	6	Maintenance					19,698	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					289	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,160	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					18,050	31
32	V	20	Fees, Subscription, Promotions					8,985	32
33	V	21	Clerical & General Office Expenses					274,923	33
34	V	22	Employee Benefits & Payroll Taxes					37,103	34
35	V	23	Inservice Training & Education					1,137	35
36	V	24	Travel and Seminar					5,873	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					15,564	38
39	Total			\$			\$ 0	\$ * 388,987	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					25,598	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					275	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,560	20
21	V	35	Rent-Equipment & Vehicles					8,380	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	\$ * 39,813	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 Staunton# 0048876

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	90	\$ 4,708	1
2	2	Food Purchase	Beds	2,571	26	0	0	90	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	90	34	3
4	4	Laundry	Beds	2,571	26	0	0	90	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	90	1,463	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	90	19,698	6
7	7	Other	Beds	2,571	26	0	0	90	0	7
8	9	Medical Director	Beds	2,571	26	0	0	90	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	90	289	9
10	11	Activities	Beds	2,571	26	0	0	90	0	10
11	12	Social Service	Beds	2,571	26	0	0	90	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	90	1,160	12
13	14	Program Transportation	Beds	2,571	26	0	0	90	0	13
14	15	Other	Beds	2,571	26	0	0	90	0	14
15	17	Administrative	Beds	2,571	26	0	0	90	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	90	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	90	18,050	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	90	8,985	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	90	274,923	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	90	37,103	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	90	1,137	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	90	5,873	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	90	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	90	15,564	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 388,987	25

Facility Name & ID Number Heritage Health Staunton # 0048876 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	\$	\$	90	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		90	25,598	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			90		3
4	32	Interest	Beds	2,571	26	7,851		90	275	4
5	33	Real Estate Taxes	Beds	2,571	26			90		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		90	5,560	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		90	8,380	7
8	36	Other	Beds	2,571	26			90		8
9	38	Medically Nec Transportation	Beds	2,571	26			90		9
10	39	Ancillary Service Centers	Beds	2,571	26			90		10
11	40	Barber and Beauty Shops	Beds	2,571	26			90		11
12	41	Coffee and Gift Shops	Beds	2,571	26			90		12
13	42	Other	Beds	2,571	26			90		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	\$		\$ 39,813	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America		x	Mortgage			\$					\$ 141,603	1
2	Bank of America		x	Loan Fee Amortization								5,913	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x	Working Capital								42,038	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 189,554	9
	B. Non-Facility Related*												
10	Interest Income											(110)	10
11													11
12	Allocated Corporate											275	12
13													13
14	TOTAL Non-Facility Related						\$					\$ 165	14
15	TOTALS (line 9+line14)						\$					\$ 189,719	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$32,767	2
3. Under or (over) accrual (line 2 minus line 1).				\$32,767	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$32,767	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	30,613	8	
		2012	31,575	9	
		2013	31,965	10	
		2014	32,557	11	
		2015	32,767	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

FACILITY NAME	<u>Heritage Health Staunton</u>	COUNTY	<u>Macoupin</u>
---------------	---------------------------------	--------	-----------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,700

B. General Construction Type: Exterior BrickFrame WoodNumber 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				\$ 53,090	1
2					2
3	TOTALS			\$ 53,090	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	90				\$ 2,016,995	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Laundry Room Central A/C			1996	2,869					9
10	Heritage Manor Sign			1996	1,948					10
11	Circulating Pump--Water System			1996	1,232					11
12										12
13	Roof									13
14	Window Replacement			1998	16,818					14
15	Boilers			1998	14,711					15
16				1998	32,278					16
17	Interior Painting--Materials and Labor			1999	7,875					17
18	Underground Storage Tank			1999	15,000					18
19	Plumbing ---Storage Tank			1999	1,032					19
20	Air conditioning Unit			1999	3,312					20
21	Mixing Valve--Water Heater			1999	4,269					21
22										22
23	Water Heater			2000	3,647					23
24	Water Softener			2000	3,271					24
25	Underground Storage Tank			2000						25
26										26
27	Cissell Dryer			2001						27
28	Water Heater			2001	2,967					28
29										29
30										30
31										31
32										32
33	C/O Allocation					25,598		25,598		33
34	Book Depreciation					127,211		127,211		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 Staunton

0048876

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Heater	2002	\$ 4,142	\$		\$	\$		37
38	Boiler	2002	6,349						38
39	A/C Unit	2002	3,385						39
40	Storage Tank	2002	864						40
41									41
42	A/C Unit	2003	1,015						42
43	Nurses Call Station	2003	3,774						43
44	A/C Unit	2003	3,385						44
45									45
46	Exterior door	2004	4,634						46
47	Islandaire Units	2004	7,284						47
48	Roof	2004	70,680						48
49									49
50	Ansul System	2005	2,170						50
51	Roof	2005	129,178						51
52	Furnance	2005	1,395						52
53	A/C Unit	2005	7,586						53
54	Energy Management	2005	13,035						54
55	Wall Repair	2005	1,212						55
56	Kitchen Storage	2005	8,791						56
57	Adjustment	2005	(1,090)						57
58	Fire Dampers	2006	2,798						58
59	Cable & Phone wiring	2006	8,477						59
60	Door replacement	2006	1,064						60
61	A/C Unit	2006	12,294						61
62	Driveway blacktop	2006	16,000						62
63	Exterior door	2006	60						63
64	Sanyo Unit	2006	1,830						64
65	Interior paint	2006	5,500						65
66		2006	(8,716)						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,435,320	\$ 152,809		\$ 152,809	\$	\$	70

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

Facility Name & ID Number Heritage Health Staunton

0048876

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,435,320	\$ 152,809		\$ 152,809	\$	\$	1
2 Interior Rehab-- Paint, floors & Lighting	2007	194,007						2
3 Water Meter	2007	7,953						3
4 Exterior Doors	2007	4,725						4
5 Fire Alarm	2007	41,283						5
6 Boiler	2007	3,473						6
7 HVAC	2007	18,079						7
8 Water Heater	2007	5,508						8
9 Rooftop HVAC	2007	4,290						9
10 Exhaust Fan	2007	500						10
11 adjustments	2007	(15,002)						11
12 HVAC	2008	7,886						12
13 Boiler	2008	37,955						13
14 Nurse Call System	2008	77,001						14
15 Sprinkler System	2008	74,332						15
16								16
17 Flooring Replacement	2009	8,751						17
18								18
19 Conference room paint, flooring & labor	2010	9,876						19
20 Data equipment relocation	2010	10,197						20
21								21
22								22
23 PTAC units	2011	7,228						23
24 Water heater	2011	5,775						24
25 Landscapping	2011	3,200						25
26								26
27 Lighting Upgrade	2012	5,304						27
28 PTAC units	2012	3,742						28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,951,383	\$ 152,809		\$ 152,809	\$	\$	34

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

Facility Name & ID Number Heritage Health Staunton

0048876

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 12B, Carried Forward		\$ 2,951,383	\$ 152,809		\$ 152,809	\$	\$	1
2								2
3 Generator Replacement	2013	55,133						3
4 Water Heater	2013	8,737						4
5 PTAC Installations	2013	8,907						5
6 Replace (3) Valve Actuators & Thermostats	2013	6,454						6
7								7
8 Replace (6) PTAC Units	2014	7,581						8
9 Reface (22) Wardrobe Units	2014	29,110						9
10								10
11 Install (2) new hollow metal doors	2015	3,406						11
12 Install security doors with appropriate electronics	2015	22,769						12
13 Replace (6) PTAC units	2015	7,995						13
14 Replace compressor for PT RTU	2015	2,617						14
15 Replace AC rooftop unit for kitchen and dining room	2015	17,051						15
16								16
17 No 2016 Improvements								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)		\$ 3,121,143	\$ 152,809		\$ 152,809	\$	\$	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	\$633,065	\$26,282	\$26,282	\$		\$	71
72	Current Year Purchases	25,308						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$658,373	\$26,282	\$26,282	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2006 Chevy Uplander van	2012	\$18,608	\$2,658	\$2,658	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$18,608	\$2,658	\$2,658	\$		\$	80

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)	\$3,851,214	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$181,749	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$181,749	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: *

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

15. Is Movable equipment rental included in building rental? YES NO x
16. Rental Amount for movable equipment: \$ 10,622 Description: Televisions and office equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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		2,070		2,070
3	Classroom Wages (a)		4,965		4,965
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 7,035	\$	\$ 7,035
10	SUM OF line 9, col. 1 and 2 (e)	\$ 7,035			

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	\$		\$ 217,029	\$		\$ 217,029	1
2	Licensed Speech and Language Development Therapist		hrs			17,704			17,704	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			231,012	655		231,667	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				422,464		422,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,248			14,248	13
14	TOTAL			\$		\$ 479,993	\$ 423,119		\$ 903,112	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	\$ 457	\$	1
2	Cash-Patient Deposits	14,342		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	837,480		3
4	Supply Inventory (priced at)	11,130		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,450		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	159,042		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,046,901	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,046,901	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,516	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,342		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,505		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,856		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	<u>Bed Tax</u>	20,608		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 458,827	\$	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)	\$ 458,827	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 588,074	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,046,901	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 493,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 493,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	94,751	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)	\$ 94,751	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)	\$ 588,074	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Staunton

0048876

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,405,753	1
2	Discounts and Allowances for all Levels	(1,817,868)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,587,885	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,583,496	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,583,496	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	366	12
13	Barber and Beauty Care	9,913	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	844,827	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,807	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 860,913	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	110	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 110	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,032,404	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	762,090	31
32	Health Care	2,070,666	32
33	General Administration	1,138,447	33
	B. Capital Expense		
34	Ownership	486,280	34
	C. Ancillary Expense		
35	Special Cost Centers	480,170	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)*	\$ 4,937,653	40
41	Income before Income Taxes (line 30 minus line 40)**	94,751	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 94,751	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	1,684	1,773	\$ 63,831	\$ 36.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	10,040	10,568	309,588	29.29	3
4	Licensed Practical Nurses	8,940	9,411	223,313	23.73	4
5	CNAs & Orderlies	46,264	48,699	685,445	14.08	5
6	CNA Trainees	560	590	4,965	8.42	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,377	1,449	32,544	22.46	8
9	Activity Director					9
10	Activity Assistants	4,077	4,292	47,936	11.17	10
11	Social Service Workers	1,732	1,823	39,480	21.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,081	13,769	165,190	12.00	15
16	Dishwashers					16
17	Maintenance Workers	2,973	3,130	51,121	16.33	17
18	Housekeepers	9,602	10,107	111,614	11.04	18
19	Laundry	3,824	4,025	38,942	9.68	19
20	Administrator	1,984	2,088	90,780	43.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,935	4,142	97,309	23.49	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)	110,073	115,866	\$ 1,962,058 *	\$ 16.93	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		21,025		36
37	Medical Records Consultant		594		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,301		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		2,216		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,136		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		0		51
52	Certified Nurse Assistants/Aides		102,722		52
53	TOTAL (lines 50 - 52)		\$ 102,722		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Heritage Health Staunton

0048876

Report Period Beginning:

01/01/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Joann Newell

\$ 90,780

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

(List each licensed administrator separately.)

\$ 90,780

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

\$ 210,298

ADP

Payroll tax processing

1,230

Tango Inc

ACA compliance

514

Cooperative Home Care

Home care consulting

500

Chamlin Associates

Engineering studies

2,975

Legal adj to Zero

26,364

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

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

\$ 241,881

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 59,645

Unemployment Compensation Insurance

20,602

FICA Taxes

150,097

Employee Health Insurance

120,321

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Benefits

14,536

Central Office Allocation

37,103

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

\$ 402,304

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

8,109

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

1,412

PR

7,918

Dues & Subscriptions

7,789

License & Fees

1,077

Central Office Allocation

8,985

Less: Public Relations Expense

(7,918)

Non-allowable advertising

(4,196)

Yellow page advertising (

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

\$ 23,176

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

1,299

27

Seminar Expense

2,174

1,499

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

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?
If YES, give association name and amount.

Yes
HCCI

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
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?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 181,425

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 445

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ 0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Sulaski & Webb

(18)

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

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

None Claimed

	Region	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	Q23	Q24	Q25	Q26	Q27	Q28	Q29	Q30	Q31	Q32	Q33	Q34	Q35	Q36	Q37	Q38	Q39	Q40	Q41	Q42	Q43	Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58	Q59	Q60	Q61	Q62	Q63	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q72	Q73	Q74	Q75	Q76	Q77	Q78	Q79	Q80	Q81	Q82	Q83	Q84	Q85	Q86	Q87	Q88	Q89	Q90	Q91	Q92	Q93	Q94	Q95	Q96	Q97	Q98	Q99	Q100	Q101	Q102	Q103	Q104	Q105	Q106	Q107	Q108	Q109	Q110	Q111	Q112	Q113	Q114	Q115	Q116	Q117	Q118	Q119	Q120	Q121	Q122	Q123	Q124	Q125	Q126	Q127	Q128	Q129	Q130	Q131	Q132	Q133	Q134	Q135	Q136	Q137	Q138	Q139	Q140	Q141	Q142	Q143	Q144	Q145	Q146	Q147	Q148	Q149	Q150	Q151	Q152	Q153	Q154	Q155	Q156	Q157	Q158	Q159	Q160	Q161	Q162	Q163	Q164	Q165	Q166	Q167	Q168	Q169	Q170	Q171	Q172	Q173	Q174	Q175	Q176	Q177	Q178	Q179	Q180	Q181	Q182	Q183	Q184	Q185	Q186	Q187	Q188	Q189	Q190	Q191	Q192	Q193	Q194	Q195	Q196	Q197	Q198	Q199	Q200	Q201	Q202	Q203	Q204	Q205	Q206	Q207	Q208	Q209	Q210	Q211	Q212	Q213	Q214	Q215	Q216	Q217	Q218	Q219	Q220	Q221	Q222	Q223	Q224	Q225	Q226	Q227	Q228	Q229	Q230	Q231	Q232	Q233	Q234	Q235	Q236	Q237	Q238	Q239	Q240	Q241	Q242	Q243	Q244	Q245	Q246	Q247	Q248	Q249	Q250	Q251	Q252	Q253	Q254	Q255	Q256	Q257	Q258	Q259	Q260	Q261	Q262	Q263	Q264	Q265	Q266	Q267	Q268	Q269	Q270	Q271	Q272	Q273	Q274	Q275	Q276	Q277	Q278	Q279	Q280	Q281	Q282	Q283	Q284	Q285	Q286	Q287	Q288	Q289	Q290	Q291	Q292	Q293	Q294	Q295	Q296	Q297	Q298	Q299	Q300	Q301	Q302	Q303	Q304	Q305	Q306	Q307	Q308	Q309	Q310	Q311	Q312	Q313	Q314	Q315	Q316	Q317	Q318	Q319	Q320	Q321	Q322	Q323	Q324	Q325	Q326	Q327	Q328	Q329	Q330	Q331	Q332	Q333	Q334	Q335	Q336	Q337	Q338	Q339	Q340	Q341	Q342	Q343	Q344	Q345	Q346	Q347	Q348	Q349	Q350	Q351	Q352	Q353	Q354	Q355	Q356	Q357	Q358	Q359	Q360	Q361	Q362	Q363	Q364	Q365	Q366	Q367	Q368	Q369	Q370	Q371	Q372	Q373	Q374	Q375	Q376	Q377	Q378	Q379	Q380	Q381	Q382	Q383	Q384	Q385	Q386	Q387	Q388	Q389	Q390	Q391	Q392	Q393	Q394	Q395	Q396	Q397	Q398	Q399	Q400	Q401	Q402	Q403	Q404	Q405	Q406	Q407	Q408	Q409	Q410	Q411	Q412	Q413	Q414	Q415	Q416	Q417	Q418	Q419	Q420	Q421	Q422	Q423	Q424	Q425	Q426	Q427	Q428	Q429	Q430	Q431	Q432	Q433	Q434	Q435	Q436	Q437	Q438	Q439	Q440	Q441	Q442	Q443	Q444	Q445	Q446	Q447	Q448	Q449	Q450	Q451	Q452	Q453	Q454	Q455	Q456	Q457	Q458	Q459	Q460	Q461	Q462	Q463	Q464	Q465	Q46
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Heritage Manor Staunton
HFS ID# 205437628001
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	(50,544)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(130,881)
		<u>(181,425)</u>
Provider Participation Fee	Line 42	<u>181,425</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(422,464)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(14,248)
		<u>(436,712)</u>
Ancillary Service Centers	Line 39	<u>436,712</u>