

		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.

<p>I. IDPH License ID Number: <u>0048041</u></p> <p>Facility Name: <u>Heritage Health Mt Sterling</u></p> <p>Address: <u>435 Camden Road</u> <u>Mt Sterling</u> <u>62353</u> <small>Number City Zip Code</small></p> <p>County: <u>Brown</u></p> <p>Telephone Number: <u>(217) 773-3377</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dave Underwood</u> Telephone Number: <u>309 823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP & CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # () </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP & CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP & CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Heritage Health Mt Sterling

0048041 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	80	29,868	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	87	TOTALS	80	29,868	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,611	10,172	1,049	21,832	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,611	10,172	1,049	21,832	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.09%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 7/2006

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

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 1,049

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 Mt Sterling # 0048041 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	174,490	10,859		185,349		185,349	4,185	189,534		1
2	Food Purchase		172,337		172,337		172,337		172,337		2
3	Housekeeping	78,440	26,453		104,893		104,893	30	104,923		3
4	Laundry	26,203	6,043		32,246		32,246		32,246		4
5	Heat and Other Utilities			71,701	71,701		71,701	1,300	73,001		5
6	Maintenance	45,051	50,647	49,746	145,444		145,444	17,505	162,949		6
7	Other (specify):*										7
8	TOTAL General Services	324,184	266,339	121,447	711,970		711,970	23,020	734,990		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,142,994	73,088	27,505	1,243,587		1,243,587	(8,427)	1,235,160		10
10a	Therapy		359,665	3,324	362,989	(362,347)	642		642		10a
11	Activities	43,196	115		43,311		43,311		43,311		11
12	Social Services	41,054		1,269	42,323		42,323		42,323		12
13	CNA Training							1,031	1,031		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,227,244	432,868	35,098	1,695,210	(362,347)	1,332,863	(7,396)	1,325,467		16
	C. General Administration										
17	Administrative	83,055			83,055		83,055		83,055		17
18	Directors Fees										18
19	Professional Services			180,300	180,300		180,300	(159,049)	21,251		19
20	Dues, Fees, Subscriptions & Promotions			191,049	191,049	(174,269)	16,780	(45)	16,735		20
21	Clerical & General Office Expenses	93,940	15,016	17,928	126,884		126,884	244,376	371,260		21
22	Employee Benefits & Payroll Taxes			332,662	332,662		332,662	32,980	365,642		22
23	Inservice Training & Education			4,702	4,702		4,702	1,011	5,713		23
24	Travel and Seminar			2,495	2,495		2,495	2,504	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,843	34,843		34,843	13,835	48,678		26
27	Other (specify):*			(4,567)	(4,567)		(4,567)	4,567			27
28	TOTAL General Administration	176,995	15,016	759,412	951,423	(174,269)	777,154	140,179	917,333		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,728,423	714,223	915,957	3,358,603	(536,616)	2,821,987	155,803	2,977,790		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.

Facility Name & ID Number

Heritage Health Mt Sterling

#0048041

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation							159,609	159,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,237	37,237		37,237	23,429	60,666			32
33	Real Estate Taxes							35,060	35,060			33
34	Rent-Facility & Grounds			381,060	381,060		381,060	(376,118)	4,942			34
35	Rent-Equipment & Vehicles			4,166	4,166		4,166	7,449	11,615			35
36	Other (specify):*											36
37	TOTAL Ownership			422,463	422,463		422,463	(150,571)	271,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			233,995	233,995	362,347	596,342	(59,782)	536,560			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					174,269	174,269		174,269			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			233,995	233,995	536,616	770,611	(59,782)	710,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,728,423	714,223	1,572,415	4,015,061		4,015,061	(54,550)	3,960,511			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Health Mt Sterling

0048041

Report Period Beginning:

01/01/16

Ending:

12/31/16

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(5)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,391)			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	(2,717)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,994)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	4,567			24
25	Fund Raising, Advertising and Promotional	(8,032)			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)	\$ (12,572)		\$	30

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	2	
		Amount	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)	(41,978)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,978)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (54,550)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Heritage Health Mt Sterling

ID# 0048041

Report Period Beginning: 01/01/16

Ending: 12/31/16

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		(4,994)	19	22
23				23
24		4,567	27	24
25		(8,032)	20	25
26				26
27		(5)	6	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	(8,464)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mt Sterling# 0048041

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	4,185	0	0	0	0	0	0	0	0	4,185	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	30	0	0	0	0	0	0	0	0	30	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,300	0	0	0	0	0	0	0	0	1,300	5
6	Maintenance	(5)	0	17,510	0	0	0	0	0	0	0	0	17,505	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5)	0	23,025	0	0	0	0	0	0	0	0	23,020	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	(8,684)	257	0	0	0	0	0	0	0	0	(8,427)	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	1,031	0	0	0	0	0	0	0	0	1,031	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	(8,684)	1,288	0	0	0	0	0	0	0	0	(7,396)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,994)	(170,099)	16,044	0	0	0	0	0	0	0	0	(159,049)	19
20	Fees, Subscriptions & Promotions	(8,032)	0	7,987	0	0	0	0	0	0	0	0	(45)	20
21	Clerical & General Office Expenses	0	0	244,376	0	0	0	0	0	0	0	0	244,376	21
22	Employee Benefits & Payroll Taxes	0	0	32,980	0	0	0	0	0	0	0	0	32,980	22
23	Inservice Training & Education	0	0	1,011	0	0	0	0	0	0	0	0	1,011	23
24	Travel and Seminar	(2,717)	0	5,221	0	0	0	0	0	0	0	0	2,504	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	13,835	0	0	0	0	0	0	0	0	13,835	26
27	Other (specify):*	4,567	0	0	0	0	0	0	0	0	0	0	4,567	27
28	TOTAL General Administration	(11,176)	(170,099)	321,454	0	0	0	0	0	0	0	0	140,179	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,181)	(178,783)	345,767	0	0	0	0	0	0	0	0	155,803	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mt Sterling# 0048041

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	136,855	0	22,754	0	0	0	0	0	0	0	159,609	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,391)	24,576	0	244	0	0	0	0	0	0	0	23,429	32
33	Real Estate Taxes	0	35,060	0	0	0	0	0	0	0	0	0	35,060	33
34	Rent-Facility & Grounds	0	(381,060)	0	4,942	0	0	0	0	0	0	0	(376,118)	34
35	Rent-Equipment & Vehicles	0	0	0	7,449	0	0	0	0	0	0	0	7,449	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,391)	(184,569)	0	35,389	0	0	0	0	0	0	0	(150,571)	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	(59,782)	0	0	0	0	0	0	0	0	0	(59,782)	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	(59,782)	0	0	0	0	0	0	0	0	0	(59,782)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(12,572)	(423,134)	345,767	35,389	0	0	0	0	0	0	0	(54,550)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy	0.00%	\$ (8,684)	\$ (8,684)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(59,782)	(59,782)	3
4	V	19 Adjustment for Related Organization	170,099	Heritage Operations Group, LLC	0.00%		(170,099)	4
5	V							5
6	V	34 Adjustment for Related Organization	381,060	Heritage Manor Real Estate, LLC	0.00%		(381,060)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		35,060	35,060	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		22,633	22,633	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		136,855	136,855	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,943	1,943	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 551,159			\$ 128,025	\$ * (423,134)	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		\$	\$	4,185	15	
16	V	2 Food Purchase						0	16	
17	V	3 Housekeeping						30	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						1,300	19	
20	V	6 Maintenance						17,510	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						257	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,031	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						16,044	31	
32	V	20 Fees, Subscription, Promotions						7,987	32	
33	V	21 Clerical & General Office Expenses						244,376	33	
34	V	22 Employee Benefits & Payroll Taxes						32,980	34	
35	V	23 Inservice Training & Education						1,011	35	
36	V	24 Travel and Seminar						5,221	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						13,835	38	
39	Total		\$			\$	0	\$ *	345,767	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						22,754 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						244 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						4,942 20
21	V	35 Rent-Equipment & Vehicles						7,449 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							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	0	\$ * 35,389 39

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

Facility Name & ID Number Heritage Health Mt Sterling # 0048041 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Health Mt Sterling

0048041

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

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	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	80	\$ 4,185	1
2	2	Food Purchase	Beds	2,571	26	0	0	80	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	80	30	3
4	4	Laundry	Beds	2,571	26	0	0	80	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	80	1,300	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	80	17,510	6
7	7	Other	Beds	2,571	26	0	0	80	0	7
8	9	Medical Director	Beds	2,571	26	0	0	80	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	80	257	9
10	11	Activities	Beds	2,571	26	0	0	80	0	10
11	12	Social Service	Beds	2,571	26	0	0	80	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	80	1,031	12
13	14	Program Transportation	Beds	2,571	26	0	0	80	0	13
14	15	Other	Beds	2,571	26	0	0	80	0	14
15	17	Administrative	Beds	2,571	26	0	0	80	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	80	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	80	16,044	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	80	7,987	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	80	244,376	19
20	22	Employee Benefits & Payroll Tax	Beds	2,571	26	1,059,901	0	80	32,980	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	80	1,011	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	80	5,221	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	80	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	80	13,835	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 345,767	25

Facility Name & ID Number Heritage Health Mt Sterling

0048041

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization See Pg 8
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	\$	80	\$	1
2	30	Depreciation	Beds	2,571	26	731,247	80	22,754	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26		80		3
4	32	Interest	Beds	2,571	26	7,851	80	244	4
5	33	Real Estate Taxes	Beds	2,571	26		80		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824	80	4,942	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379	80	7,449	7
8	36	Other	Beds	2,571	26		80		8
9	38	Medically Nec Transportation	Beds	2,571	26		80		9
10	39	Ancillary Service Centers	Beds	2,571	26		80		10
11	40	Barber and Beauty Shops	Beds	2,571	26		80		11
12	41	Coffee and Gift Shops	Beds	2,571	26		80		12
13	42	Other	Beds	2,571	26		80		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	\$	\$ 35,389	25

Facility Name & ID Number

Heritage Health Mt Sterling

0048041

Report Period Beginning:

01/01/16

Ending:

12/31/16

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			\$	\$		\$ 22,633	1									
2	Bank of America		x	Loan Fee Amortization						1,943	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						37,237	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 61,813	9									
B. Non-Facility Related*																				
10	Interest Income									(1,391)	10									
11											11									
12	Allocated Corporate									244	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (1,147)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 60,666	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.)		\$	35,060	2
3. Under or (over) accrual (line 2 minus line 1).		\$	35,060	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.		\$	35,060	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	39,701	8
	2012	39,510	9
	2013	38,000	10
	2014	33,972	11
	2015	35,060	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Mt Sterling COUNTY Brown

FACILITY IDPH LICENSE NUMBER 0048041

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-194-001-00</u>	_____	\$ <u>35,060.10</u>	\$ <u>35,060.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>35,060.10</u></u>	\$ <u><u>35,060.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Heritage Health Mt Sterling

0048041

Report Period Beginning:

01/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,650 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, Use, Square Feet, Year Acquired, \$ 125,400, 1. Row 2: 2, Use, Square Feet, Year Acquired, \$, 2. Row 3: 3 TOTALS, Use, Square Feet, Year Acquired, \$ 125,400, 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	Accumulated Depreciation
4	80			\$ 914,680	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9	1987 Improvements	1987		17,047				
10	1987 Improvements	1987		73,700				
11	1988 Improvements	1988		25,324				
12	1989 Improvements	1989		64,856				
13	1990 Improvements	1990		14,699				
14	1991 Improvements	1991		18,519				
15	1992 Improvements	1992		18,102				
16	1993 Improvements	1993		54,992				
17	1994 Improvements	1994		114,380				
18	1995 Improvements	1995		22,646				
19	Fire Alarm System	1996		27,410				
20	Electrical Wire--Resident Rooms	1996		2,675				
21	Drainage System	1996		5,100				
22	Code Alert	1996		6,916				
23	Resident Room Remodel	1996		26,925				
24	Physical Therapy Room Remodel	1996		6,725				
25								
26								
27								
28								
29								
30								
31								
32								
33	C/O Allocation				22,754		22,754	
34	Book Depreciation				99,734		99,734	
35								
36								

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Mt Sterling# 0048041

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	
37	Shower/Remodel	1997	\$ 6,033	\$		\$	\$	\$	37
38	Air Conditioner	1997	1,365						38
39	Resident Room Remodel	1997	199,404						39
40									40
41	Garbage Disposal	1998	797						41
42									42
43	Gerator Repair	1999	5,712						43
44	Kitchen Air Conditioner	1999	1,450						44
45									45
46	Door Monitor System	2000	5,196						46
47	Water Heater	2000	3,995						47
48	Sink Installation & Faucet	2000	1,736						48
49									49
50	Water Main Repair	2001	2,308						50
51	Water Heater	2001	3,016						51
52									52
53	A/C Unit	2002	2,634						53
54									54
55	A/C Unit	2003	3,024						55
56	Seal Asphalt	2003	3,538						56
57	Roof	2003	9,616						57
58	Sewer Repair	2003	2,275						58
59	A/C Unit	2003	1,377						59
60	Door	2003	2,283						60
61	Water Softener	2003	1,375						61
62									62
63	Door Alarm	2004	900						63
64	Doors	2004	1,127						64
65	Kick Plates	2004	2,181						65
66	A/C Unit	2004	6,105						66
67	Water Softener	2004	4,197						67
68	Wallguard/Wallcoverings	2004	8,138						68
69	Carpet	2004	1,027						69
70	TOTAL (lines 4 thru 69)		\$ 1,695,505	\$ 122,488		\$ 122,488	\$	\$	70

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

Facility Name & ID Number Heritage Health Mt Sterling

0048041

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		\$ 1,695,505	\$ 122,488		\$ 122,488	\$	\$	1
2	Drainage System	2005	5,803						2
3	Beverage Center	2005	4,299						3
4	Gutters and downspouts	2005	2,485						4
5	Hvac	2005	4,259						5
6	A/C unit	2005	2,423						6
7	Wallguard coverings	2005	8,715						7
8	Window blinds	2005	631						8
9									9
10	A/C unit	2006	5,340						10
11	Concrete Replacement	2006	9,275						11
12	Floor tile	2006	2,046						12
13	North Wing floor replacement	2006	17,047						13
14	Remodel -- Paint/wallpaper	2006	9,212						14
15	Closet Door	2006	619						15
16	Capital Report Adj	2006							16
17	Overbed lights	2007	10,463						17
18	Smoke detectors	2007							18
19	Hot Water Boiler	2007	10,154						19
20	Hand rail	2007							20
21	HVAC	2007	6,945						21
22	Air Handler	2007	2,540						22
23	Water heater	2007	3,066						23
24	Water heater	2007	3,556						24
25	Windows - North wing	2007	27,463						25
26	North Wing floor replacement	2007	3,353						26
27	Gazebo	2007							27
28	Flooring	2007							28
29	Exit lights	2007							29
30	Water Line	2007	2,805						30
31	Adjustment--audit	2007							31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,838,004	\$ 122,488		\$ 122,488	\$	\$	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,838,004	\$ 122,488		\$ 122,488	\$	\$	1
2	Purchase & Installation of Sprinklers -- closets, resident rooms	2008	14,878						2
3	Roof	2008	7,744						3
4	A/C Units	2008	2,610						4
5	Heat/cool Unit	2008	6,354						5
6	Trane A/C & air handling unit	2008	5,305						6
7	North Wing Remodel -- Paint Rooms, Overbed lights & Supplies	2008	4,224						7
8	Capital Report Adj	2008							8
9	HVAC Unit	2009	3,395						9
10	Drainage Improvements	2009	255,630						10
11	Air Handler	2009	3,430						11
12									12
13	Water Heater	2010	3,821						13
14	HVAC Unit	2010	6,786						14
15	Memory Unit -- window treatments, patient wandering stations	2010	18,931						15
16	flooring, including all labor of installation.								16
17									17
18	Memory Unit -- window treatments, patient wandering stations	2011	26,325						18
19	flooring, including all labor of installation.								19
20	Dinning room chandelier	2011	9,320						20
21	Sprinkler valve	2011	5,000						21
22	Trane airhandler	2011	4,110						22
23	Electric Heater	2011	4,124						23
24	Water Heater	2011	5,100						24
25	Landscapping	2011	2,557						25
26	Sign	2011	4,150						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,231,798	\$ 122,488		\$ 122,488	\$	\$	34

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

Facility Name & ID Number Heritage Health Mt Sterling

0048041

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 12C, Carried Forward		\$ 2,231,798	\$ 122,488		\$ 122,488	\$	\$	1
2									2
3	Heat/Cool Units	2012	6,577						3
4	Shower Room Remodel	2012	15,010						4
5	Water Softener	2012	2,500						5
6									6
7									7
8	Shower Room - New flooring and wall tile	2013	11,141						8
9	Fire Sprinler System	2013	66,095						9
10	Ten (10) Heating/Cooling Units	2013	6,160						10
11	Hot Water Boiler	2013	6,714						11
12									12
13									13
14	Window Casing Replacement - Entire Facility	2014	85,577						14
15									15
16	Nurse Call System cabling and electronics	2015	183,566						16
17	Radiator replacement on generator set	2015	3,479						17
18	Install (10) new PTAC units	2015	7,515						18
19	Install new meter controlled water softener	2015	5,279						19
20	Install new life safety panel	2015	3,200						20
21	Replace back door - fire paneled with new concrete	2015	4,840						21
22									22
23	Install Luxaire gas furnace	2016	2,995						23
24	Shower room floor demolition and installation of new tile	2016	5,687						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,648,133	\$ 122,488		\$ 122,488	\$	\$	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	\$ 854,344	\$ 32,699	\$ 32,699	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 854,344	\$ 32,699	\$ 32,699	\$		\$	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		2010 Town & Country Van	2012	\$ 30,953	\$ 4,422	\$ 4,422	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 30,953	\$ 4,422	\$ 4,422	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,658,830	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,609	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,609	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

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	\$ _____

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

16. Rental Amount for movable equipment: \$ 4,166 Description: Televisions

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	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	\$		\$ 89,242	\$		\$ 89,242	1
2	Licensed Speech and Language Development Therapist		hrs			8,684			8,684	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			136,069	642		136,711	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				359,023		359,023	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					3,324			3,324	13
14	TOTAL			\$		\$ 237,319	\$ 359,665		\$ 596,984	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	\$ 845	\$	1
2	Cash-Patient Deposits	7,547		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	768,282		3
4	Supply Inventory (priced at)	15,609		4
5	Short-Term Investments			5
6	Prepaid Insurance	20,631		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,484,100)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (671,186)	\$	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)	\$ (671,186)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 107,093	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,577		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,240		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,319		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>	21,427		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 261,656	\$	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)	\$ 261,656	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (932,842)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (671,186)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,016,413)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,016,413)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	83,571	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)	\$ 83,571	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)	\$ (932,842)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,632,275	1
2	Discounts and Allowances for all Levels	(1,030,821)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,601,454	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	773,508	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 773,508	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	126	12
13	Barber and Beauty Care	315	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	711,007	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,831	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 722,279	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,391	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,391	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,098,632	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	711,970	31
32	Health Care	1,695,210	32
33	General Administration	951,423	33
B. Capital Expense			
34	Ownership	422,463	34
C. Ancillary Expense			
35	Special Cost Centers	233,995	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)*	\$ 4,015,061	40
41	Income before Income Taxes (line 30 minus line 40)**	83,571	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 83,571	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.

Facility Name & ID Number Heritage Health Mt Sterling

0048041

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	1,815	1,910	\$ 62,025	\$ 32.47	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,039	5,304	146,849	27.69	3
4	Licensed Practical Nurses	13,719	14,441	324,154	22.45	4
5	CNAs & Orderlies	40,311	42,433	562,627	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,732	1,823	47,339	25.97	8
9	Activity Director					9
10	Activity Assistants	3,661	3,854	43,196	11.21	10
11	Social Service Workers	1,775	1,868	41,054	21.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,414	16,225	174,490	10.75	15
16	Dishwashers					16
17	Maintenance Workers	2,584	2,720	45,051	16.56	17
18	Housekeepers	7,495	7,889	78,440	9.94	18
19	Laundry	2,623	2,761	26,203	9.49	19
20	Administrator	1,984	2,088	83,055	39.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,193	4,414	93,940	21.28	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)	102,345	107,730	\$ 1,728,423 *	\$ 16.04	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	3,000		36
37	Medical Records Consultant	2,159		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,097		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	1,269		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,525		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	21,249		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	\$ 21,249		53

Facility Name & ID Number Heritage Health Mt Sterling

0048041

Report Period Beginning: 01/01/16

Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$ 83,055	Workers' Compensation Insurance	\$ 20,362	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,750	Advertising: Employee Recruitment	3,014	
				FICA Taxes	132,224	Health Care Worker Background Check (Indicate # of checks performed)	1,450	
				Employee Health Insurance	145,141			
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Benefits	15,185	PR	2,936	
				Central Office Allocation	32,980	Dues & Subscriptions	6,431	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,055			License & Fees	877	
B. Administrative - Other						Central Office Allocation	7,987	
Description			Amount			Less: Public Relations Expense	(2,936)	
			\$			Non-allowable advertising	(3,024)	
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 365,642	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,735	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgmt		\$ 170,098			\$	Out-of-State Travel	\$
ADP	Payroll Tax processing		1,181					
Tango Inc	ACA Compliance		442					
Chamlin Associates	Engineering survey		2,825				In-State Travel	
McKee Environmental	Update Phase 1		760					1,724
								27
							Seminar Expense	744
								2,504
							Entertainment Expense (
Legal adj to Zero			4,994				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 180,300	TOTAL		\$	TOTAL	\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

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. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 174,269
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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 605
- (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? _____
 - 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? _____
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor Mt. Sterling
HFS ID# 203903543001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

Add (Subtract)

Reclassification of Provider Participation Fees

Provider Participation Fee - \$1.50	Line 20, Col 3	(44,802)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(129,467)
		<u>(174,269)</u>
Provider Participation Fee	Line 42	<u>174,269</u>

Reclassification of Ancillary Services Cost

Cost of Drugs Purchased	Line 10(a), Col 2	(359,023)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(3,324)
		<u>(362,347)</u>
Ancillary Service Centers	Line 39	<u>362,347</u>