

		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>0048892</u></p> <p>Facility Name: <u>Heritage Health Gillespie</u></p> <p>Address: <u>7588 Staunton Road</u> <u>Gillespie</u> <u>62033</u> <small>Number City Zip Code</small></p> <p>County: <u>Macoupin</u></p> <p>Telephone Number: <u>(217) 839-2171</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2007</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 Gillespie

0048892 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	118	Skilled (SNF)	100	38,112	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	118	TOTALS	100	38,112	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	14,608	8,179	2,677	25,464	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,608	8,179	2,677	25,464	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.81%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started July 2007

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 2,677

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 Gillespie # 0048892 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	196,787	8,870		205,657		205,657	5,231	210,888		1
2	Food Purchase		199,906		199,906		199,906		199,906		2
3	Housekeeping	115,420	20,593		136,013		136,013	38	136,051		3
4	Laundry	51,243	13,105		64,348		64,348		64,348		4
5	Heat and Other Utilities			80,954	80,954		80,954	1,625	82,579		5
6	Maintenance	40,886	29,809	55,386	126,081		126,081	21,887	147,968		6
7	Other (specify):*										7
8	TOTAL General Services	404,336	272,283	136,340	812,959		812,959	28,781	841,740		8
	B. Health Care and Programs										
9	Medical Director			22,932	22,932		22,932		22,932		9
10	Nursing and Medical Records	1,441,936	87,557	8,502	1,537,995		1,537,995	(18,948)	1,519,047		10
10a	Therapy		464,882	25,614	490,496	(488,012)	2,484		2,484		10a
11	Activities	38,404	2,809		41,213		41,213		41,213		11
12	Social Services	37,500		1,082	38,582		38,582		38,582		12
13	CNA Training							1,289	1,289		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,517,840	555,248	58,130	2,131,218	(488,012)	1,643,206	(17,659)	1,625,547		16
	C. General Administration										
17	Administrative	75,000			75,000		75,000		75,000		17
18	Directors Fees										18
19	Professional Services			252,630	252,630		252,630	(208,986)	43,644		19
20	Dues, Fees, Subscriptions & Promotions			216,508	216,508	(197,118)	19,390	3,399	22,789		20
21	Clerical & General Office Expenses	138,918	19,908	24,223	183,049		183,049	305,470	488,519		21
22	Employee Benefits & Payroll Taxes			395,439	395,439		395,439	41,225	436,664		22
23	Inservice Training & Education			6,433	6,433		6,433	1,264	7,697		23
24	Travel and Seminar			5,340	5,340		5,340	(341)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			53,113	53,113		53,113	17,294	70,407		26
27	Other (specify):*			(25,364)	(25,364)		(25,364)	25,364			27
28	TOTAL General Administration	213,918	19,908	928,322	1,162,148	(197,118)	965,030	184,689	1,149,719		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,136,094	847,439	1,122,792	4,106,325	(685,130)	3,421,195	195,811	3,617,006		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 Gillespie

#0048892

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							222,374	222,374			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,748	47,748		47,748	161,890	209,638			32
33	Real Estate Taxes							30,540	30,540			33
34	Rent-Facility & Grounds			516,900	516,900		516,900	(510,722)	6,178			34
35	Rent-Equipment & Vehicles			12,799	12,799		12,799	9,311	22,110			35
36	Other (specify):*											36
37	TOTAL Ownership			577,447	577,447		577,447	(86,607)	490,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			504,064	504,064	488,012	992,076	(104,801)	887,275			39
40	Barber and Beauty Shops		685	21,670	22,355		22,355		22,355			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					197,118	197,118		197,118			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		685	525,734	526,419	685,130	1,211,549	(104,801)	1,106,748			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,136,094	848,124	2,225,973	5,210,191		5,210,191	4,403	5,214,594			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.)

		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				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	7,696			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	(6,867)			19
20	Contributions	(100)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,894)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	25,464			24
25	Fund Raising, Advertising and Promotional	(6,585)			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)	\$ 14,714		\$	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)	(10,311)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (10,311)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,403		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 Gillespie

ID# 0048892

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		(4,894)	19	22
23				23
24		25,464	27	24
25		(6,585)	20	25
26				26
27		(100)	27	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	13,885		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Gillespie# 0048892

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	5,231	0	0	0	0	0	0	0	0	5,231	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	38	0	0	0	0	0	0	0	0	38	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,625	0	0	0	0	0	0	0	0	1,625	5
6	Maintenance	0	0	21,887	0	0	0	0	0	0	0	0	21,887	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	28,781	0	28,781	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	(19,269)	321	0	0	0	0	0	0	0	0	(18,948)	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	1,289	0	0	0	0	0	0	0	0	1,289	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	(19,269)	1,610	0	(17,659)	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	(4,894)	(224,147)	20,055	0	0	0	0	0	0	0	0	(208,986)	19
20	Fees, Subscriptions & Promotions	(6,585)	0	9,984	0	0	0	0	0	0	0	0	3,399	20
21	Clerical & General Office Expenses	0	0	305,470	0	0	0	0	0	0	0	0	305,470	21
22	Employee Benefits & Payroll Taxes	0	0	41,225	0	0	0	0	0	0	0	0	41,225	22
23	Inservice Training & Education	0	0	1,264	0	0	0	0	0	0	0	0	1,264	23
24	Travel and Seminar	(6,867)	0	6,526	0	0	0	0	0	0	0	0	(341)	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	17,294	0	0	0	0	0	0	0	0	17,294	26
27	Other (specify):*	25,364	0	0	0	0	0	0	0	0	0	0	25,364	27
28	TOTAL General Administration	7,018	(224,147)	401,818	0	184,689	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	7,018	(243,416)	432,209	0	195,811	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Gillespie

0048892

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	193,932	0	28,442	0	0	0	0	0	0	0	222,374	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	7,696	153,889	0	305	0	0	0	0	0	0	0	161,890	32
33	Real Estate Taxes	0	30,540	0	0	0	0	0	0	0	0	0	30,540	33
34	Rent-Facility & Grounds	0	(516,900)	0	6,178	0	0	0	0	0	0	0	(510,722)	34
35	Rent-Equipment & Vehicles	0	0	0	9,311	0	0	0	0	0	0	0	9,311	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,696	(138,539)	0	44,236	0	(86,607)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(104,801)	0	0	0	0	0	0	0	0	0	(104,801)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	(104,801)	0	0	0	0	0	0	0	0	0	(104,801)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	14,714	(486,756)	432,209	44,236	0	4,403	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%	\$ (19,269)	\$ (19,269)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(104,801)	(104,801)	3
4	V	19 Adjustment for Related Organization	224,147	Heritage Operations Group, LLC	0.00%		(224,147)	4
5	V							5
6	V	34 Adjustment for Related Organization	516,900	Heritage Manor Real Estate, LLC	0.00%		(516,900)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		30,540	30,540	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		148,210	148,210	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		193,932	193,932	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,679	5,679	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 741,047			\$ 254,291	\$ * (486,756)	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		\$	\$	5,231 15
16	V	2 Food Purchase						0 16
17	V	3 Housekeeping						38 17
18	V	4 Laundry						0 18
19	V	5 Heat & Other Utilities						1,625 19
20	V	6 Maintenance						21,887 20
21	V	7 Other						0 21
22	V	9 Medical Director						0 22
23	V	10 Nursing & Medical Records						321 23
24	V	11 Activities						0 24
25	V	12 Social Service						0 25
26	V	13 Nurse Aide Training						1,289 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						20,055 31
32	V	20 Fees, Subscription, Promotions						9,984 32
33	V	21 Clerical & General Office Expenses						305,470 33
34	V	22 Employee Benefits & Payroll Taxes						41,225 34
35	V	23 Inservice Training & Education						1,264 35
36	V	24 Travel and Seminar						6,526 36
37	V	25 Other Admin. Staff Transportation						0 37
38	V	26 Insurance-Prop.Liab.Malpract						17,294 38
39	Total		\$			\$	0	\$ * 432,209 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						28,442 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						305 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						6,178 20
21	V	35 Rent-Equipment & Vehicles						9,311 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	\$ * 44,236 39

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

Facility Name & ID Number

Heritage Health Gillespie

0048892

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	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 Gillespie

0048892

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	100	\$ 5,231	1
2	2	Food Purchase	Beds	2,571	26	0	0	100	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	100	38	3
4	4	Laundry	Beds	2,571	26	0	0	100	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	100	1,625	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	100	21,887	6
7	7	Other	Beds	2,571	26	0	0	100	0	7
8	9	Medical Director	Beds	2,571	26	0	0	100	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	100	321	9
10	11	Activities	Beds	2,571	26	0	0	100	0	10
11	12	Social Service	Beds	2,571	26	0	0	100	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	100	1,289	12
13	14	Program Transportation	Beds	2,571	26	0	0	100	0	13
14	15	Other	Beds	2,571	26	0	0	100	0	14
15	17	Administrative	Beds	2,571	26	0	0	100	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	100	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	100	20,055	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	100	9,984	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	100	305,470	19
20	22	Employee Benefits & Payroll Tax	Beds	2,571	26	1,059,901	0	100	41,225	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	100	1,264	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	100	6,526	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	100	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	100	17,294	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 432,209	25

Facility Name & ID Number Heritage Health Gillespie

0048892

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	\$	100	\$	1
2	30	Depreciation	Beds	2,571	26	731,247	100	28,442	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26		100		3
4	32	Interest	Beds	2,571	26	7,851	100	305	4
5	33	Real Estate Taxes	Beds	2,571	26		100		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824	100	6,178	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379	100	9,311	7
8	36	Other	Beds	2,571	26		100		8
9	38	Medically Nec Transportation	Beds	2,571	26		100		9
10	39	Ancillary Service Centers	Beds	2,571	26		100		10
11	40	Barber and Beauty Shops	Beds	2,571	26		100		11
12	41	Coffee and Gift Shops	Beds	2,571	26		100		12
13	42	Other	Beds	2,571	26		100		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	\$	\$ 44,236	25

Facility Name & ID Number

Heritage Health Gillespie

0048892

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	Busey Bank		x	Mortgage			\$	\$		\$ 148,210	1									
2	Busey Bank		x	Loan Fee Amortization						5,679	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						47,748	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 201,637	9									
B. Non-Facility Related*																				
10	Interest Income									7,696	10									
11											11									
12	Allocated Corporate									305	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 8,001	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 209,638	15									

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

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

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

Facility Name & ID Number Heritage Health Gillespie

0048892

Report Period Beginning:

01/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,300 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, 27,045, 1. Row 2: 2, 2. Row 3: 3 TOTALS, 27,045, 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	100			\$ 3,578,055	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9	Roof Repair		1997	2,275				
10	Storage Tank		1997	1,857				
11								
12	Heritage Manor Sign		1996	1,896				
13	Laundry Room A/C		1996	3,019				
14								
15	Garbage Disposal		1998	730				
16	Roof		1998	90,404				
17								
18	Water Heater		1999	3,596				
19	Air Conditioning Unit		1999	1,145				
20	Smoke Dampers/Fire Alarm Replacem		1999	5,802				
21	Interior Painting--Materials and Labor		1999	2,459				
22	Roof		1999	29,985				
23								
24	Interior Painting--Materials and Labor		2000	3,923				
25								
26	Booster Heater		2001	1,903				
27	Telephone System Add-on		2001	62				
28								
29	A/C Rooftop Unit		2002	2,703				
30								
31								
32								
33	C/O Allocation				28,442		28,442	
34	Book Depreciation				162,773		162,773	
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

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	A/C Units	2003	\$ 8,858	\$		\$	\$	\$	37
38	Asphalt Sealing	2003	2,408						38
39	Ansul System --Kitchen	2003	1,465						39
40									40
41	Front Door	2004	3,893						41
42	Heat Cool Unit	2004	4,522						42
43									43
44	Windows	2005	6,255						44
45	HVAC	2005	10,675						45
46	Rooftop A/C	2005	6,663						46
47	Parking Lot Sealer	2005	2,358						47
48	Wallcoverings	2005	597						48
49	Sidewalks	2005	4,444						49
50	Floor Replacement	2005	18,756						50
51	Boiler	2005	6,388						51
52									52
53	A/C Units	2006	6,865						53
54	Rooftop A/C	2006	8,234						54
55	Five Ton Condensing Unit	2006	2,980						55
56	Pump	2006							56
57	Exterior Door	2006							57
58	Boiler	2006	5,396						58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,830,571	\$ 191,215		\$ 191,215	\$	\$	70

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

Facility Name & ID Number Heritage Health Gillespie# 0048892

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		\$ 3,830,571	\$ 191,215		\$ 191,215	\$	\$	1
2	HVAC	2007	3,430						2
3	Steamer Install	2007							3
4	Corridor Remodel	2007							4
5	HVAC	2007	3,024						5
6	Sprinkler Heads	2007	2,569						6
7	Boiler	2007	11,881						7
8	Plumbing	2007	2,949						8
9									9
10	Facility Rehab -- Paint, flooring, lighting	2008	227,268						10
11	Exterior Door	2008	4,150						11
12	Boilers	2008	16,293						12
13	Nurse Call System	2008	123,168						13
14	Window Replacement	2008	54,925						14
15	Parking Lot	2008	37,142						15
16	Wireless System	2008	10,017						16
17	Cabling	2008	5,785						17
18	Alarm System	2008	8,804						18
19									19
20	Rehab: Paint, window treatments, paint & labor	2009	27,218						20
21	Landscaping rock	2009	4,501						21
22	Rooftop A/C	2009	8,678						22
23	Sewer pump	2009	9,150						23
24	Nurse Call System	2009	88,196						24
25									25
26	Carpeting: conference room		2,929						26
27	Relocate/Install data equipment		10,251						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,492,899	\$ 191,215		\$ 191,215	\$	\$	34

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

Facility Name & ID Number Heritage Health Gillespie# 0048892

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 12B, Carried Forward		\$ 4,492,899	\$ 191,215		\$ 191,215	\$	\$	1
2	PTAC units	2011	7,591						2
3	Condensing Unit	2011	5,461						3
4	Condensing Unit	2011	11,480						4
5	Carpet	2011	24,911						5
6	PTAC units	2011	3,796						6
7	Resident Room Flooring	2011	13,125						7
8									8
9	Carpet	2012	3,332						9
10	Shower Room	2012	8,493						10
11	Water Heater	2012	3,632						11
12	Walk-in Cooler	2012	33,299						12
13	Lighting Upgrade	2012	5,446						13
14									14
15	Front Parking Lot Paving	2013	53,996						15
16	Water Heater	2013	6,750						16
17	PTAC Units	2013	4,089						17
18									18
19	Replace 6 PTAC Units	2014	6,686						19
20	Remove and Rebuild Exterior Wall	2014	8,583						20
21	Parking Lot Fill, Seal and Striping	2014	4,386						21
22									22
23	Install (6) new PTAC units	2015	9,604						23
24	Replacement of air conditioning unit - therapy	2015	6,035						24
25	Install bath, shower and wall tile - bathing room	2015	6,833						25
26									26
27	Install new 100 gallon water heater	2016	5,200						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,725,627	\$ 191,215		\$ 191,215	\$	\$	34

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

Facility Name & ID Number Heritage Health Gillespie

0048892

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 979,268	\$ 31,159	\$ 31,159	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 979,268	\$ 31,159	\$ 31,159	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,731,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,374	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,374	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.

Facility Name & ID Number Heritage Health Gillespie

0048892

Report Period Beginning: 01/01/16

Ending: 12/31/16

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: \$ 12,799 Description: Televisions and office machines

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$		\$ 270,947	\$		\$ 270,947	1
2	Licensed Speech and Language Development Therapist		hrs			49,757			49,757	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			183,360	2,484		185,844	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				462,398		462,398	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					25,614			25,614	13
14	TOTAL			\$		\$ 529,678	\$ 464,882		\$ 994,560	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	\$ 1,079	\$	1
2	Cash-Patient Deposits	16,409		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	996,969		3
4	Supply Inventory (priced at)	11,728		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,365		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(216,806)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 837,744	\$	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)	\$ 837,744	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,441	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,409		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	285,956		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,269		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>	24,347		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 481,422	\$	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)	\$ 481,422	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 356,322	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 837,744	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,392	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 175,392	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	180,930	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)	\$ 180,930	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)	\$ 356,322	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	\$ 4,800,973	1
2	Discounts and Allowances for all Levels	(1,847,864)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,953,109	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,526,425	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,526,425	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,084	12
13	Barber and Beauty Care	15,466	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	899,665	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,068	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 919,283	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(7,696)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (7,696)	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)	\$ 5,391,121	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	812,959	31
32	Health Care	2,131,218	32
33	General Administration	1,162,148	33
B. Capital Expense			
34	Ownership	577,447	34
C. Ancillary Expense			
35	Special Cost Centers	526,419	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,210,191	40
41	Income before Income Taxes (line 30 minus line 40)**	180,930	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 180,930	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 Gillespie

0048892

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	1,845	1,942	\$ 68,566	\$ 35.31	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,622	4,866	145,090	29.82	3
4	Licensed Practical Nurses	16,791	17,675	413,011	23.37	4
5	CNAs & Orderlies	51,281	53,980	740,180	13.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,564	2,699	75,089	27.82	8
9	Activity Director					9
10	Activity Assistants	3,019	3,178	38,404	12.08	10
11	Social Service Workers	1,715	1,805	37,500	20.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,091	16,939	196,787	11.62	15
16	Dishwashers					16
17	Maintenance Workers	2,102	2,213	40,886	18.48	17
18	Housekeepers	10,413	10,961	115,420	10.53	18
19	Laundry	4,017	4,228	51,243	12.12	19
20	Administrator	1,984	2,088	75,000	35.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,247	5,523	138,918	25.15	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)	121,691	128,097	\$ 2,136,094 *	\$ 16.68	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	22,932		36
37	Medical Records Consultant	871		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,614		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	1,046		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 29,463		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Health Gillespie# 0048892Report Period Beginning: 01/01/16Ending: 12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs
- (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. \$ 197,118
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. \$ 528
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor Gillespie
HFS ID# 205508113001
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	(57,168)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(139,950)
		<u>(197,118)</u>
Provider Participation Fee	Line 42	<u>197,118</u>

Reclassification of Ancillary Services Cost

Cost of Drugs Purchased	Line 10(a), Col 2	(462,398)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(25,614)
		<u>(488,012)</u>
Ancillary Service Centers	Line 39	<u>488,012</u>