FOR BHF USE							

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0048116

Facility Name: Heritage Health Gibson City

Address: 620 E 1st Street (Number) Gibson City (City) 60936 (Zip Code)

County: Ford

Telephone Number: (217) 784-4257 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code ____
- [x] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [x] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ____
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other ____

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed) ____ (Date)
	(Type or Print Name) David M Underwood
	(Title) EVP & CFO
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,450	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	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,847	4,059	950	17,856	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,847	4,059	950	17,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.05%

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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

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 [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified ____________ and days of care provided 950

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: ____________ Fiscal Year: ____________

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	184,198	7,183		191,381		191,381	3,923	195,304			1
2	Food Purchase		129,779		129,779		129,779		129,779			2
3	Housekeeping	59,076	16,259		75,335		75,335	28	75,363			3
4	Laundry	47,394	6,738		54,132		54,132		54,132			4
5	Heat and Other Utilities			47,363	47,363		47,363	1,219	48,582			5
6	Maintenance	51,958	48,771	51,591	152,320		152,320	16,415	168,735			6
7	Other (specify):*											7
8	**TOTAL General Services**	342,626	208,730	98,954	650,310		650,310	21,585	671,895			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,158,241	67,803	105,251	1,331,295		1,331,295	(8,914)	1,322,381			10
10a	Therapy		352,988	8,060	361,048	(360,437)	611		611			10a
11	Activities	46,280	2,272		48,552		48,552		48,552			11
12	Social Services	36,137		3,196	39,333		39,333		39,333			12
13	CNA Training							966	966			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,240,658	423,063	128,507	1,792,228	(360,437)	1,431,791	(7,948)	1,423,843			16
	C. General Administration											
17	Administrative	86,000			86,000		86,000		86,000			17
18	Directors Fees											18
19	Professional Services			161,797	161,797		161,797	(145,128)	16,669			19
20	Dues, Fees, Subscriptions & Promotions			166,665	166,665	(142,647)	24,018	(1,857)	22,161			20
21	Clerical & General Office Expenses	138,558	18,789	22,178	179,525		179,525	229,103	408,628			21
22	Employee Benefits & Payroll Taxes			332,556	332,556		332,556	30,919	363,475			22
23	Inservice Training & Education			7,877	7,877		7,877	(1,421)	6,456			23
24	Travel and Seminar			2,602	2,602		2,602	2,397	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			33,737	33,737		33,737	12,970	46,707			26
27	Other (specify):* Lost Resident Items			31,573	31,573		31,573	(31,528)	45			27
28	**TOTAL General Administration**	224,558	18,789	758,985	1,002,332	(142,647)	859,685	95,455	955,140			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,807,842	650,582	986,446	3,444,870	(503,084)	2,941,786	109,092	3,050,878			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 Gibson City #0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation							116,925	116,925			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,053	34,053		34,053	19,288	53,341			32
33	Real Estate Taxes							38,074	38,074			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,867)	4,633			34
35	Rent-Equipment & Vehicles			37,399	37,399		37,399	6,983	44,382			35
36	Other (specify):*											36
37	TOTAL Ownership			399,952	399,952		399,952	(142,597)	257,355			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			287,830	287,830	360,437	648,267	(75,159)	573,108			39
40	Barber and Beauty Shops			3,329	3,329		3,329		3,329			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					142,647	142,647		142,647			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			291,159	291,159	503,084	794,243	(75,159)	719,084			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,807,842	650,582	1,677,557	4,135,981		4,135,981	(108,664)	4,027,317			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 Gibson City # 0048116 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(261)			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	(2,497)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,503)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,528)			24
25	Fund Raising, Advertising and Promotional	(9,345)			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)**	$ (57,134)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(51,530)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (51,530)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (108,664)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heritage Health Gibson City

ID# 0048116

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		(13,503)	19	22
23				23
24		(31,528)	27	24
25		(9,345)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(54,376)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 A. General Services	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)	
1	Dietary	0	0	3,923	0	0	0	0	0	0	0	0	3,923	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	28	0	0	0	0	0	0	0	0	28	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,219	0	0	0	0	0	0	0	0	1,219	5
6	Maintenance	0	0	16,415	0	0	0	0	0	0	0	0	16,415	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	21,585	0	0	0	0	0	0	0	0	21,585	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	(9,155)	241	0	0	0	0	0	0	0	0	(8,914)	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	966	0	0	0	0	0	0	0	0	966	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	(9,155)	1,207	0	0	0	0	0	0	0	0	(7,948)	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	(13,503)	(146,666)	15,041	0	0	0	0	0	0	0	0	(145,128)	19
20	Fees, Subscriptions & Promotions	(9,345)	0	7,488	0	0	0	0	0	0	0	0	(1,857)	20
21	Clerical & General Office Expenses	0	0	229,103	0	0	0	0	0	0	0	0	229,103	21
22	Employee Benefits & Payroll Taxes	0	0	30,919	0	0	0	0	0	0	0	0	30,919	22
23	Inservice Training & Education	0	(2,369)	948	0	0	0	0	0	0	0	0	(1,421)	23
24	Travel and Seminar	(2,497)	0	4,894	0	0	0	0	0	0	0	0	2,397	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	12,970	0	0	0	0	0	0	0	0	12,970	26
27	Other (specify):*	(31,528)	0	0	0	0	0	0	0	0	0	0	(31,528)	27
28	**TOTAL General Administration**	(56,873)	(149,035)	301,363	0	0	0	0	0	0	0	0	95,455	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,873)	(158,190)	324,155	0	0	0	0	0	0	0	0	109,092	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 D. Ownership	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)	
30	Depreciation	0	95,593	0	21,332	0	0	0	0	0	0	0	116,925	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(261)	19,320	0	229	0	0	0	0	0	0	0	19,288	32
33	Real Estate Taxes	0	38,074	0	0	0	0	0	0	0	0	0	38,074	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,633	0	0	0	0	0	0	0	(323,867)	34
35	Rent-Equipment & Vehicles	0	0	0	6,983	0	0	0	0	0	0	0	6,983	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(261)	(175,513)	0	33,177	0	0	0	0	0	0	0	(142,597)	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	(75,159)	0	0	0	0	0	0	0	0	0	(75,159)	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	(75,159)	0	0	0	0	0	0	0	0	0	(75,159)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(57,134)	(408,862)	324,155	33,177	0	0	0	0	0	0	0	(108,664)	45

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy		$ (9,155)	$ (9,155)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(2,369)	(2,369)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		(75,159)	(75,159)	3
4	V	19	Adjustment for Related Organization	146,666	Heritage Operations Group, LLC			(146,666)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC			(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		38,074	38,074	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		17,552	17,552	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		95,593	95,593	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,768	1,768	10
11	V								11
12	V								12
13	V								13
14	Total			$ 475,166			$ 66,304	$ * (408,862)	14

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [x] 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		$	$ 3,923	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					28	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,219	19
20	V	6	Maintenance					16,415	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					241	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					966	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					15,041	31
32	V	20	Fees, Subscription, Promotions					7,488	32
33	V	21	Clerical & General Office Expenses					229,103	33
34	V	22	Employee Benefits & Payroll Taxes					30,919	34
35	V	23	Inservice Training & Education					948	35
36	V	24	Travel and Seminar					4,894	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,970	38
39	Total			$			$ 0	$ * 324,155	39

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [x] 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		$	$ 0	15
16	V	30	Depreciation					21,332	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					229	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,633	20
21	V	35	Rent-Equipment & Vehicles					6,983	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 33,177	39

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

Facility Name & ID Number: Heritage Health Gibson City # 0048116 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Gibson City # 0048116 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 [x] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	$ 134,491	$ 133,835	75	$ 3,923	1
2	2	Food Purchase	Beds	2,571	26	0	0	75	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	75	28	3
4	4	Laundry	Beds	2,571	26	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	75	1,219	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	75	16,415	6
7	7	Other	Beds	2,571	26	0	0	75	0	7
8	9	Medical Director	Beds	2,571	26	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	75	241	9
10	11	Activities	Beds	2,571	26	0	0	75	0	10
11	12	Social Service	Beds	2,571	26	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	75	966	12
13	14	Program Transportation	Beds	2,571	26	0	0	75	0	13
14	15	Other	Beds	2,571	26	0	0	75	0	14
15	17	Administrative	Beds	2,571	26	0	0	75	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	75	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	75	15,041	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	75	7,488	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	75	229,103	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	75	30,919	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	75	948	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	75	4,894	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	75	12,970	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 324,155	25

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	$	$	75	$	1
2	30	Depreciation	Beds	2,571	26	731,247		75	21,332	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			75		3
4	32	Interest	Beds	2,571	26	7,851		75	229	4
5	33	Real Estate Taxes	Beds	2,571	26			75		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		75	4,633	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		75	6,983	7
8	36	Other	Beds	2,571	26			75		8
9	38	Medically Nec Transportation	Beds	2,571	26			75		9
10	39	Ancillary Service Centers	Beds	2,571	26			75		10
11	40	Barber and Beauty Shops	Beds	2,571	26			75		11
12	41	Coffee and Gift Shops	Beds	2,571	26			75		12
13	42	Other	Beds	2,571	26			75		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	$		$ 33,177	25

Facility Name & ID Number Heritage Health Gibson City # 0048116 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			$	$			$ 17,552	1
2	Bank of America		x	Loan Fee Amortization							1,768	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							34,053	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 53,373	9
	B. Non-Facility Related*											
10	Interest Income										(261)	10
11												11
12	Allocated Corporate										229	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (32)	14
15	TOTALS (line 9+line14)						$	$			$ 53,341	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ____________ 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 Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)	$	38,074	2
3. Under or (over) accrual (line 2 minus line 1).	$	38,074	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.	$	38,074	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	33,608	8
	2012	33,358	9
	2013	33,780	10
	2014	34,956	11
	2015	38,074	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 Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

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)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	09-11-11-482-001		$ 37,911.68	$ 37,912.00
2.	09-11-11-479-017		$ 162.14	$ 162.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,073.82	$ 38,074.00

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 ______ 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 Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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 [x] (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 [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75				$ 815,350	$		$	$	$	4
5					912,769						5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Improvements										9
10	1982 Improvements										10
11	1983 Improvements										11
12	1984 Improvements										12
13	1985 Improvements										13
14	1986 Improvements										14
15	1987 Improvements										15
16	1988 Improvements										16
17	1989 Improvements										17
18	1990 Improvements										18
19	1991 Improvements										19
20	1993 Improvements										20
21	1994 Improvements										21
22	1995 Improvements										22
23	WINDOW REPLACEMENTS										23
24	WATER HEATER										24
25	RESIDENT ROOM REMODEL/PAINTING										25
26	Parking Lot										26
27											27
28	Smoke Dampers										28
29	Water Heater										29
30	Garbage Disposal										30
31	Heat/Cool compressor										31
32	Smoke Dampers										32
33											33
34	C/O Allocation					21,332		21,332			34
35	Book Depreciation					83,478		83,478			35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Temperature Control Unit	2001	$ 1,700	$		$	$	$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,838,539	$ 104,810		$ 104,810	$	$	70

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,838,539	$ 104,810		$ 104,810	$	$	1
2	Oxygen Room	2005	2,005						2
3	Heat/Cool Unit	2005	17,228						3
4									4
5	Heat/Cool Units	2006	25,182						5
6	Door	2006	2,887						6
7	Heater	2006	1,078						7
8	Sidewalk	2006	3,500						8
9	Boiler	2006	1,427						9
10	Remodel TLC Unit --carpet, paint,	2006	27,516						10
11	Parking Lot sealer	2006	1,699						11
12	Drapes	2006	1,172						12
13	adjustments	2006	(7,711)						13
14	dishwasher motor	2007							14
15	Remodel TLC Unit --carpet, paint,	2007	2,996						15
16	Water Heater	2007	2,907						16
17	Grease Trap	2007							17
18	Water Softener	2007	12,285						18
19									19
20	Emergency Alarms	2008	36,893						20
21									21
22	Water Heater	2008	4,982						22
23	Exterior Painting	2008	9,720						23
24									24
25	Sprinkler System	2009	11,980						25
26	Water Heater	2009	4,503						26
27	Generator	2009	26,450						27
28									28
29	Water Heater	2010	3,750						29
30	Generator	2010	43,596						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,074,584	$ 104,810		$ 104,810	$	$	34

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,074,584	$ 104,810		$ 104,810	$	$	1
2									2
3	Micromatic Scrubber	2011	3,932						3
4	Duro-Last Roofing	2001	9,600						4
5	Trane Rooftop Unit	2001	23,888						5
6									6
7	Water Heater	2012	3,808						7
8	Lighting Retrofit	2012	5,860						8
9									9
10	Doors	2013	4,698						10
11	Feezer Condensation Unit	2013	8,198						11
12									12
13	Replace Roof	2014	96,012						13
14	Replace Backwater Valve	2014	4,044						14
15									15
16	Installed water heater	2015	4,228						16
17	Replace generator control board	2015	3,385						17
18	Remodeled front entrance and lobby areas - new flooring,	2015	46,794						18
19	painting, cabinets and gables								19
20									20
21	Add new circuit panel	2016	3,160						21
22	Install hot water storage tank	2016	4,200						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,296,391	$ 104,810		$ 104,810	$	$	34

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	$ 568,490	$ 10,560	$ 10,560	$		$	71
72	Current Year Purchases	9,109						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 577,599	$ 10,560	$ 10,560	$		$	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		2017 Dodge Grand Caravan	2016	$ 43,540	$ 1,555	$ 1,555	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 43,540	$ 1,555	$ 1,555	$		$	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)	$ 2,937,530	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 116,925	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 116,925	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 Gibson City # 0048116 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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .
9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending
11. Rent to be paid in future years under the current rental agreement:

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 37,399 Description: Mattresses, beds, copiers and 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	None		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [ ] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 151,570	$		$ 151,570	1
2	Licensed Speech and Language Development Therapist		hrs			7,474			7,474	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			128,786	611		129,397	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				352,377		352,377	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					8,060			8,060	13
14	TOTAL			$		$ 295,890	$ 352,988		$ 648,878	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.

STATE OF ILLINOIS

Facility Name & ID Number **Heritage Health Gibson City** **# 0048116** **Report Period Beginning: 01/01/16** **Ending: 12/31/16**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of 12/31/16** **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,704	$	1
2	Cash-Patient Deposits	5,777		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	898,802		3
4	Supply Inventory (priced at)	11,673		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,607		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(4,143,317)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (3,204,754)	$	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)**	$ (3,204,754)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 76,991	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,777		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,461		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,683		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	17,882		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 273,794	$	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)**	$ 273,794	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,478,548)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (3,204,754)	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,857,797)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,857,797)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(620,751)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (620,751)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,478,548)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,011,894	1
2	Discounts and Allowances for all Levels	(1,089,669)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,922,225	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	925,375	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 925,375	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	1,470	12
13	Barber and Beauty Care	4,873	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	661,174	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(148)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 667,369	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	261	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 261	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)**	$ 3,515,230	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	650,310	31
32	Health Care	1,792,228	32
33	General Administration	1,002,332	33
	B. Capital Expense		
34	Ownership	399,952	34
	C. Ancillary Expense		
35	Special Cost Centers	291,159	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)***	$ 4,135,981	40
41	**Income before Income Taxes (line 30 minus line 40)****	(620,751)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (620,751)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? ____________ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	1,846	1,944	$ 70,911	$ 36.48	1
2	Assistant Director of Nursing	205	216	4,935	22.85	2
3	Registered Nurses	8,160	8,590	285,247	33.21	3
4	Licensed Practical Nurses	8,296	8,733	224,290	25.68	4
5	CNAs & Orderlies	34,697	36,523	572,968	15.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			(110)		8
9	Activity Director					9
10	Activity Assistants	2,793	2,940	46,280	15.74	10
11	Social Service Workers	1,688	1,777	36,137	20.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,392	15,150	184,198	12.16	15
16	Dishwashers					16
17	Maintenance Workers	2,954	3,110	51,958	16.71	17
18	Housekeepers	4,759	5,009	59,076	11.79	18
19	Laundry	2,917	3,071	47,394	15.43	19
20	Administrator	1,984	2,088	86,000	41.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,063	5,330	138,558	26.00	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)	89,754	94,481	$ 1,807,842 *	$ 19.13	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		12,000		36
37	Medical Records Consultant		2,380		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,245		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,196		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,821		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$ 2,520		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		97,439		52
53	TOTAL (lines 50 - 52)		$ 99,959		53

Facility Name & ID Number: Heritage Health Gibson City # 0048116 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Gronsky			$ 86,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgmt	$ 146,666
ADP	Payroll Tax Processing	1,191
Tango	ACA Consultant	437
Kretchmer & Assoc.	Market Consultant	9,492
Legal adj to Zero		4,011
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 161,797

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,057
Unemployment Compensation Insurance	21,275
FICA Taxes	138,300
Employee Health Insurance	126,860
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	14,064
Central Office Allocation	30,919
TOTAL (agree to Schedule V, line 22, col.8)	$ 363,475

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,216
Health Care Worker Background Check (Indicate # of checks performed)	1,508
PR	5,098
Dues & Subscriptions	6,405
License & Fees	4,972
Central Office Allocation	7,488
Less: Public Relations Expense	(5,098)
Non-allowable advertising	(3,428)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,161

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,205
	42
Seminar Expense	1,355
	2,397
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**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. **HCCI**

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

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

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

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

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **142,647**
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. $ **2,314**

(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? ____ 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

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount	
1009			PETTY CASH	2,704						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	898,802						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1135			ACCOUNTS RECEIVABLE-IC							
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	19,607						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY							
1310			SUPPLIES INVENTORY	11,673						
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	0						
1460			ACCUM DEPR-FURN & EQUI	0						
1475			BUILDING & IMPROVEMENT	0						
1490			ACCUM DEPR-BUILDING	0						
1530			RESIDENT FUNDS	5,777						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	-4,143,317						
2010			ACCOUNTS PAYABLE	-76,991						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-82,454						
2110			ACCRUED VACATION PAY	-88,007						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-2,683	-2,683					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYAI	0						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-17,882						
2350			REAL ESTATE TAX PAYABL	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS	0						
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-5,777						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	2,857,797						
2970			PROFIT/LOSS FOR PERIOD	620,751						
3007.1			PATIENT DAYS-PRIVATE	4,059						
3007.2			PATIENT DAYS-IPA	12,847						
3007.3			PATIENT DAYS-MEDICARE	950						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE &	-2,984,812		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	0		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	0		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVAT	-23,533		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-661,174		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-925,375		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT II	101,472						
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	1,089,669		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-4,873		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	-1,470		0	0	0	0	
3570		12	VENDING INCOME/EXPENSI	0		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-3,549		0	0	0	0	
3595		21	RESIDENT TRANSPORTATIC	0		0	0	0	0	
3600		21	MISC INCOME	148		0	0	0	0	
4110			GENERAL & ADMINIST WAC	129,940	138,558	21	1	17	0	
4111			ADMINISTRATOR WAGES	86,000	86,000	17	1	0	0	
4115			VACATION & SICK - G&A	8,618		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	14,064	332,556	22	3	0	0	
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0	
4130			EMPLOYEE SCHOLORSHIP V	0	101,472	21	1	0	0	
4135			EMPLOYEE SCHOLORSHIP (	0		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	18,789	18,789	21	2	0	0	
4260			TELEPHONE	22,178	22,178	21	3	0	0	
4275			TRAINING & EMPLOYEE DE	7,877	7,877	23	3	16	0 **	
4280			GENERAL TRAVEL	1,205	2,602	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVE	42		24	3	19	0	
4285			EDUCATION & SEMINAR	1,355		24	3	19	-2,497 ***	
4290			HELP WANTED ADVERTISIN	5,216	65,193	20	3	0	0	-41,175
4291			PROMOTIONAL ADVERTISII	819		20	3	25	-819	
4292			PUBLIC RELATIONS	5,098		20	3	25	-5,098	
4300			LICENSES & FEES	46,147		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	6,405		20	3	17	-3,428	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	15,131	161,797	19	3	22	-13,503	
4355			MEDICAL DIRECTOR	12,000	12,000	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSU	2,380		10	3	0	0	
4363			PHARMACIST FEES	3,245		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3,196	3,196	12	3	0	0	
4370			TV RENTAL	7,239		35	3	5	0	
4380			INCOME TAXES		31,573	27	3	26	0	
4383			BACKGROUND CHECKS	1,508		20	3	26	0	
4400			PAYROLL TAXES	150,648		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	8,927		22	3	0	0	
4410			GROUP INSURANCE	126,860		22	3	0	0	
4420			LIABILITY INSURANCE	33,737	33,737	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURAI	32,057		22	3	0	0	
4450			CENTRAL OFFICE FEES	146,666		19	3	34	0 **	
4460			BAD DEBTS	31,528		27	3	24	-31,528	
4470			LOST ITEMS-RESIDENTS	45		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	30,160	37,399	35	3	16	0	
5110			MAINTENANCE SALARIES	48,122	51,958	6	1	0	0	
5120			MAINTENANCE SICK & VAC	3,836		6	1	0	0	
5130			ELECTRIC	29,603	47,363	5	3	0	0	
5131			NATURAL GAS	12,369		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	5,391		5	3	0	0	
5134			TRASH COLLECTION	9,591	51,591	6	3	0	0	
5140			PROPERTY PLANT REPLACE	4,555	48,771	6	2	0	0	
5160			GENERAL REPAIR & MAINT	44,216		6	2	0	0	
5165			MAINTENANCE CONTRACT	42,000		6	3	0	0	
5210			DIETARY WAGES	170,803	184,198	1	1	0	0	
5220			DIETARY SICK & VAC	13,395		1	1	0	0	
5240			SALES TAX			2	3	13	0	
5248			FOOD PURCHASES	132,093	129,779	2	2	0	0	
5250			SUPPLIES-DISHWASHING	6,737	7,183	1	2	0	0	
5260			DIETARY REPLACEMENT	143		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	303		1	2	0	0	
5295			MEAL CREDIT	-2,314		2	2	0	0	
5310			LAUNDRY WAGES	44,445	47,394	4	1	0	0	
5340			LAUNDRY SICK & VAC	2,949		4	1	0	0	
5370			LAUNDRY REPLACEMENT	4,059	6,738	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	2,679		4	2	0	0	
5410			HOUSEKEEPING WAGES	53,221	59,076	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	5,855		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	15,425	16,259	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-F	834		3	2	0	0	
6010			RN WAGES-MEDICARE		1,158,241	10	1	0	0	
6020			RN WAGES-NON MEDICARE	262,248		10	1	0	0	

1,009	1,009	CASH	2,704
1,100	1,100	ACCTS RI	990,401
1,101	1,101	ALLOW. I	(91,599)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID	19,607
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVENTORY	
1,310	1,310	SUPPLIES	11,673
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITU	0
1,460			0
1,475	1,475	BUILDIN	0
1,490	1,490	ACCUM I	0
1,530	1,530	RESIDEN	5,777
1,550	1,550	LOAN FE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	(4,143,317)
2,010	2,010	ACCOUN	(76,991)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEI	(82,454)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEI	(88,007)
2,120	2,120	U.C. TAX	0
2,125	2,125	FICA TAX	(2,683)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GA	0
2,300	2,300	ACCRUEI	0
2,320	2,320	IPA PAYM	(17,882)
2,350	2,350	REAL EST	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO F	(5,777)
2,600	2,600	LASALLE	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINE	2,857,797
		net income	620,751
		balance	0
3,007	3,007	PATIENT DAYS-	4,059
3,007	3,007	PATIENT DAYS-	12,847
3,007	3,007	PATIENT DAYS-	950
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHARGE	(2,984,812)
3,020	3,020	BASIC CHARGE	0
3,030	3,030	BASIC CHARGE	0
3,040			101,472
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SUPPL	(23,533)
3,081	3,081	NURSING SUPPL	0
3,082	3,082	NURSING SUPPL	0
3,083	3,083	NURSING SUPPL	0
3,100	3,100	DRUGS-MEDICA	(661,174)
3,101			0
3,110	3,110	PHYSICAL THEI	(925,375)
3,111			0
3,112	3,112	PHYSICAL THEI	0
3,113	3,113	PHYSICAL THEI	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THERAPY	0
3,153	3,153	ST/OT THERAPY	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER DISC	0
3,411	3,411	MEDICARE PT B	0
3,420	3,420	MEDICARE DISC	1,052,196
3,500			
3,520	3,520	RENT INCOME	0
3,530	3,530	BEAUTY SHOP	(4,873)
3,560			(1,470)
3,570	3,570		
3,590	3,590	EQUIPMENT RE	(3,549)
3,595	3,595	RESIDENT TRAN	0
3,600	3,600	MISC INCOME	148
4,110	4,110	G&A WAGES	129,940
4,111	4,111	ADMINISTRATC	86,000
4,115	4,115	G&A PTO & RES	8,618
4,120	4,120	EMPLOYEE BEN	14,285
4,121			
4,130	4,130	EMPLOYEE SCH	0
4,135	4,135	EMPLOYEE SCH	0
4,250	4,250	OFFICE SUPPLIE	8,876
4,255	4,255	POSTAGE	1,986
4,260	4,260	TELEPHONE	22,178
4,275	4,275	TRAINING & EM	7,877
4,276			135
4,280	4,280	GENERAL TRAV	1,205
4,281	4,281	MEAL EXPENSE	42
4,285	4,285	EDUCATION/SEI	800
4,289	4,289	MEETINGS EXPI	555
4,290	4,290	HELP WANTED	5,216
4,291	4,291	PROMOTIONAL	819
4,292	4,292	PUBLIC RELATI	5,098
4,300	4,300	LICENSE & FEES	46,147
4,310	4,310	DUES & SUBSCF	6,405
4,320	4,320	CONTRIBUTION	0
4,350	4,350	PROFESSIONAL	15,131
4,355	4,355	MEDICAL DIREC	12,000
4,362			2,380
4,363			3,245
4,364	4,364	SOCIAL SERV/A	3,196
4,370	4,370	TV RENTAL	7,239
4,383	4,383	BACKGROUND	1,508
4,390	4,390	OTHER TAXES	0
4,400	4,400	PAYROLL TAXE	150,648
4,401	4,401	PAYROLL TAXE	8,927
4,410	4,410	GROUP INSURA	126,860
4,420	4,420	LIABILITY INSU	33,737
4,430	4,430	WORKMAN'S CC	28,422
4,435	4,435	W/C-FIRST AID	2,465
4,436	4,436	DRUG TESTING	1,035
4,450	4,450	MANAGEMENT	146,666
4,460	4,460	BAD DEBTS	31,528
4,461	4,461	BAD DEBTS	37,473
4,470	4,470	LOST ITEMS-RE	45
4,475	4,475	UNIFORM EXP/F	(221)
4,486	4,486	M.I.S. Software	20,069
4,490	4,490	MISC EXPENSE	900
4,496	4,496	MISC. M.I.S. EXI	7,927
4,510	4,510	REAL ESTATE T	0
4,600	4,600	LEASED EQUIPN	30,160
5,110	5,110	MAINTENANCE	48,122
5,120	5,120	MAINTENANCE	3,836
5,130	5,130	ELECTRIC	29,603
5,131	5,131	NATURAL GAS	12,369
5,133	5,133	WATER & SEWE	5,391
5,134	5,134	TRASH COLLEC	9,591
5,140	5,140	PROP/PLANT RE	4,555
5,160	5,160	GENERAL REPA	44,216
5,165	5,165	MAINTENANCE	21,931
5,210	5,210	DIETARY WAGE	170,803
5,220	5,220	DIETARY PTO &	13,395
5,248	5,248	FOOD PURCHAS	131,193
5,250	5,250	SUPPLIES DISHV	6,737
5,260	5,260	REPLACEMENT-	143
5,270	5,270	KITCHEN SUPPL	303
5,295	5,295	MEAL INCOME	(2,314)
5,310	5,310	LAUNDRY WAG	44,445
5,340	5,340	LAUNDRY PTO	2,949
5,370	5,370	REPLACEMENT-	4,059
5,380			0
5,390	5,390	SUPPLIES	2,679
5,410	5,410	HOUSEKEEPING	53,221
5,440	5,440	HOUSEKEEPING	5,855
5,480	5,480	SUPPLIES-CLEA	15,425
5,490	5,490	SUPPLIES-HOUS	834
6,020	6,020	RN WAGES	262,248

Heritage Manor Gibson City
HFS ID# 203902572001
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	(41,175)
Provider Assesment Fee - $6.07	Line 20, Col 3	(101,472)
		(142,647)
Provider Participation Fee	Line 42	142,647
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(352,377)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(8,060)
		(360,437)
Ancillary Service Centers	Line 39	360,437