FOR BHF USE

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048058

Facility Name: Heritage Health Minonk

Address: 201 Locust Street (Number) Minonk (City) 61760 (Zip Code)

County: Woodford

Telephone Number: (309) 432-2557 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			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 Minonk # 0048058 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	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,418	5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,352	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	4,529	5,358	2,531	12,418	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,282		1,282	12
13	DD 16 OR LESS					13
14	TOTALS	4,529	6,640	2,531	13,700	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.99%

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 2,531

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.

Facility Name & ID Number Heritage Health Minonk # 0048058 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	181,572	10,462		192,034		192,034	3,766	195,800			1
2	Food Purchase		124,352		124,352		124,352		124,352			2
3	Housekeeping	49,953	15,685		65,638		65,638	27	65,665			3
4	Laundry	35,251	4,903		40,154		40,154		40,154			4
5	Heat and Other Utilities			63,713	63,713		63,713	1,170	64,883			5
6	Maintenance	73,163	45,053	40,380	158,596		158,596	15,759	174,355			6
7	Other (specify):*											7
8	TOTAL General Services	339,939	200,455	104,093	644,487		644,487	20,722	665,209			8
	B. Health Care and Programs											
9	Medical Director			1,162	1,162		1,162		1,162			9
10	Nursing and Medical Records	1,007,259	47,814	5,141	1,060,214		1,060,214	(11,649)	1,048,565			10
10a	Therapy		268,300	30,988	299,288	(297,807)	1,481		1,481			10a
11	Activities	70,043	7,109		77,152		77,152		77,152			11
12	Social Services	52,488		2,370	54,858		54,858		54,858			12
13	CNA Training							928	928			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,129,790	323,223	39,661	1,492,674	(297,807)	1,194,867	(10,721)	1,184,146			16
	C. General Administration											
17	Administrative	89,530			89,530		89,530		89,530			17
18	Directors Fees											18
19	Professional Services			161,304	161,304		161,304	(144,686)	16,618			19
20	Dues, Fees, Subscriptions & Promotions			118,905	118,905	(91,188)	27,717	(10,386)	17,331			20
21	Clerical & General Office Expenses	139,213	14,107	6,174	159,494		159,494	219,939	379,433			21
22	Employee Benefits & Payroll Taxes			250,104	250,104		250,104	29,682	279,786			22
23	Inservice Training & Education			4,869	4,869		4,869	910	5,779			23
24	Travel and Seminar			5,891	5,891		5,891	(892)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,934	28,934		28,934	12,452	41,386			26
27	Other (specify):*			(33,161)	(33,161)		(33,161)	33,161				27
28	TOTAL General Administration	228,743	14,107	543,020	785,870	(91,188)	694,682	140,180	834,862			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,698,472	537,785	686,774	2,923,031	(388,995)	2,534,036	150,181	2,684,217			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 Minonk #0048058 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		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							213,729	213,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,250	22,250		22,250	25,828	48,078			32
33	Real Estate Taxes							31,149	31,149			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(310,912)	4,448			34
35	Rent-Equipment & Vehicles			19,087	19,087		19,087	6,704	25,791			35
36	Other (specify):*											36
37	**TOTAL Ownership**			356,697	356,697		356,697	(33,502)	323,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			454,305	454,305	297,807	752,112	(74,153)	677,959			39
40	Barber and Beauty Shops			143	143		143		143			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					91,188	91,188		91,188			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			454,448	454,448	388,995	843,443	(74,153)	769,290			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,698,472	537,785	1,497,919	3,734,176		3,734,176	42,526	3,776,702			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 Minonk # 0048058 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27)			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	(5,591)			19
20	Contributions	(274)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,657)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	33,435			24
25	Fund Raising, Advertising and Promotional	(17,574)			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)**	$ 7,312		$	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)	35,214		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 35,214		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 42,526		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

Heritage Health Minonk

ID# 0048058

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		(2,657)	19	22
23				23
24		33,435	27	24
25		(17,574)	20	25
26				26
27		(274)	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	12,930		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Minonk **#** 0048058 **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 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)	
	A. General Services													
1	Dietary	0	0	3,766	0	0	0	0	0	0	0	0	3,766	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	27	0	0	0	0	0	0	0	0	27	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,170	0	0	0	0	0	0	0	0	1,170	5
6	Maintenance	0	0	15,759	0	0	0	0	0	0	0	0	15,759	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	20,722	0	0	0	0	0	0	0	0	20,722	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	(11,880)	231	0	0	0	0	0	0	0	0	(11,649)	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	928	0	0	0	0	0	0	0	0	928	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	(11,880)	1,159	0	0	0	0	0	0	0	0	(10,721)	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	(2,657)	(156,469)	14,440	0	0	0	0	0	0	0	0	(144,686)	19
20	Fees, Subscriptions & Promotions	(17,574)	0	7,188	0	0	0	0	0	0	0	0	(10,386)	20
21	Clerical & General Office Expenses	0	0	219,939	0	0	0	0	0	0	0	0	219,939	21
22	Employee Benefits & Payroll Taxes	0	0	29,682	0	0	0	0	0	0	0	0	29,682	22
23	Inservice Training & Education	0	0	910	0	0	0	0	0	0	0	0	910	23
24	Travel and Seminar	(5,591)	0	4,699	0	0	0	0	0	0	0	0	(892)	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	12,452	0	0	0	0	0	0	0	0	12,452	26
27	Other (specify):*	33,161	0	0	0	0	0	0	0	0	0	0	33,161	27
28	**TOTAL General Administration**	7,339	(156,469)	289,310	0	0	0	0	0	0	0	0	140,180	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	7,339	(168,349)	311,191	0	0	0	0	0	0	0	0	150,181	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Minonk # 0048058 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	193,251	0	20,478	0	0	0	0	0	0	0	213,729	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(27)	25,635	0	220	0	0	0	0	0	0	0	25,828	32
33	Real Estate Taxes	0	31,149	0	0	0	0	0	0	0	0	0	31,149	33
34	Rent-Facility & Grounds	0	(315,360)	0	4,448	0	0	0	0	0	0	0	(310,912)	34
35	Rent-Equipment & Vehicles	0	0	0	6,704	0	0	0	0	0	0	0	6,704	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(27)	(65,325)	0	31,850	0	0	0	0	0	0	0	(33,502)	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	(74,153)	0	0	0	0	0	0	0	0	0	(74,153)	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	(74,153)	0	0	0	0	0	0	0	0	0	(74,153)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,312	(307,827)	311,191	31,850	0	0	0	0	0	0	0	42,526	45

Facility Name & ID Number Heritage Health Minonk # 0048058 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	0.00%	$ (11,880)	$ (11,880)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(74,153)	(74,153)	3
4	V	19	Adjustment for Related Organization	156,469	Heritage Operations Group, LLC	0.00%		(156,469)	4
5	V								5
6	V	34	Adjustment for Related Organization	315,360	Heritage Manor Real Estate, LLC	0.00%		(315,360)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		31,149	31,149	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		23,657	23,657	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		193,251	193,251	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,978	1,978	10
11	V								11
12	V								12
13	V								13
14	Total			$ 471,829			$ 164,002	$ * (307,827)	14

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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 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)	
15	V	1	Dietary	$	Heritage Operations Group LLC		$	$ 3,766	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					27	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,170	19
20	V	6	Maintenance					15,759	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					231	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					928	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					14,440	31
32	V	20	Fees, Subscription, Promotions					7,188	32
33	V	21	Clerical & General Office Expenses					219,939	33
34	V	22	Employee Benefits & Payroll Taxes					29,682	34
35	V	23	Inservice Training & Education					910	35
36	V	24	Travel and Seminar					4,699	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,452	38
39	Total			$			$ 0	$ * 311,191	39

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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 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)	
15	V	27	Other	$	Heritage Operations Group LLC		$	$ 0	15
16	V	30	Depreciation					20,478	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					220	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,448	20
21	V	35	Rent-Equipment & Vehicles					6,704	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	$ * 31,850	39

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 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 Minonk # 0048058 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 [x]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	$ 134,491	$ 133,835	72	$ 3,766	1
2	2	Food Purchase	Beds	2,571	26	0	0	72	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	72	27	3
4	4	Laundry	Beds	2,571	26	0	0	72	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	72	1,170	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	72	15,759	6
7	7	Other	Beds	2,571	26	0	0	72	0	7
8	9	Medical Director	Beds	2,571	26	0	0	72	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	72	231	9
10	11	Activities	Beds	2,571	26	0	0	72	0	10
11	12	Social Service	Beds	2,571	26	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	72	928	12
13	14	Program Transportation	Beds	2,571	26	0	0	72	0	13
14	15	Other	Beds	2,571	26	0	0	72	0	14
15	17	Administrative	Beds	2,571	26	0	0	72	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	72	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	72	14,440	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	72	7,188	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	72	219,939	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	72	29,682	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	72	910	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	72	4,699	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	72	12,452	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 311,191	25

Facility Name & ID Number Heritage Health Minonk # 0048058 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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	$	$	72	$	1
2	30	Depreciation	Beds	2,571	26	731,247		72	20,478	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			72		3
4	32	Interest	Beds	2,571	26	7,851		72	220	4
5	33	Real Estate Taxes	Beds	2,571	26			72		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		72	4,448	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		72	6,704	7
8	36	Other	Beds	2,571	26			72		8
9	38	Medically Nec Transportation	Beds	2,571	26			72		9
10	39	Ancillary Service Centers	Beds	2,571	26			72		10
11	40	Barber and Beauty Shops	Beds	2,571	26			72		11
12	41	Coffee and Gift Shops	Beds	2,571	26			72		12
13	42	Other	Beds	2,571	26			72		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	$		$ 31,850	25

Facility Name & ID Number Heritage Health Minonk # 0048058 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			$	$			$ 23,657	1
2	Bank of America		x	Loan Fee Amortization							1,978	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							22,250	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 47,885	9
	B. Non-Facility Related*											
10	Interest Income										(27)	10
11												11
12	Allocated Corporate										220	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 193	14
15	TOTALS (line 9+line14)						$	$			$ 48,078	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 Minonk # 0048058 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	$	31,149	2
3. Under or (over) accrual (line 2 minus line 1).	$	31,149	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.	$	31,149	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	31,256	8
2012	30,973	9
2013	30,678	10
2014	31,161	11
2015	31,149	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 Minonk COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0048058

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0607407011		$ 19,202.52	$ 19,203.00
2.	0607407010		$ 11,946.16	$ 11,946.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,148.68	$ 31,149.00

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 x NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Heritage Health Minonk # 0048058 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,960 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				$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number Heritage Health Minonk # 0048058 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	72				$ 1,039,908	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detectors (45)			1998	3,267						9
10	Compressor			1998	1,047						10
11	Generator			1998	12,140						11
12	A/C Repair			1998	1,518						12
13	Plumbing Repair			1998	4,956						13
14											14
15	Water Heater			1996	2,603						15
16	Resident Room Renovating			1996	8,483						16
17	Exterior Painting & Renovation			1996	4,806						17
18	Nurse Call System			1996	3,803						18
19	Garbage Disposal			1996	867						19
20	Boiler Repair			1996	4,436						20
21	Receptionist Work Area Renovation			1996	1,260						21
22	Hot Water Heater			1996	505						22
23	Exterior Signage			1996	1,680						23
24	Interior Rehab			1996	146,288						24
25	Interior Rehab			1996	22,963						25
26	Code Alert System			1996	1,319						26
27											27
28	Interior Rehab			1997	33,578						28
29	Interior Rehab			1997	168						29
30	Building Purchase Offset				(141,199)						30
31											31
32											32
33	C/O Allocation					20,478		20,478			33
34	Book Depreciation					146,972		146,972			34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Minonk # 0048058 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	Door Alarm System	1999	$ 10,116	$		$	$	$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005							65
66		2005	6,106						66
67			2,957						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,275,235	$ 167,450		$ 167,450	$	$	70

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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		$ 1,275,235	$ 167,450		$ 167,450	$	$	1
2	Climate Control	2006	1,299						2
3	Shower Faucet	2006	444						3
4	Sprinkler main line	2006	6,672						4
5	Compressor	2006	1,580						5
6	Corridor Rehab	2006	5,855						6
7	Rooftop A/C	2006	8,235						7
8	Audit ADJ 2006	2006	(1,227)						8
9	Fire Alarm	2007	39,698						9
10	Chiller	2007	11,569						10
11	Bearing Assembly	2007	1,109						11
12	Sprinkler	2007	2,180						12
13	HVAC	2007	876						13
14	Landscaping	2007	9,585						14
15	Thermostat	2007	7,722						15
16	Audit ADJ 2007	2007	(6,433)						16
17	Nurse Call System	2008	125,184						17
18	Soffit & Facia	2008	14,880						18
19	Water Heater	2008	9,193						19
20	Wonderguard	2008	8,777						20
21	Wireless phone system	2008	22,250						21
22	Cables for Nurse Call system	2008	9,897						22
23									23
24	Shower Faucet	2009	6,569						24
25	Front Doors	2009	6,370						25
26	Sprinkler System	2009	43,180						26
27	Water Heater	2009	7,017						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,617,716	$ 167,450		$ 167,450	$	$	34

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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		$ 1,617,716	$ 167,450		$ 167,450	$	$	1
2									2
3	Air Compressor	2010	2,800						3
4	Remodel: Paint resident rooms/labor & flooring	2010	50,213						4
5	Data System	2010	9,854						5
6	Garage Heater	2010	2,831						6
7									7
8	Facility Remodel: Flooring, Paint, lighting & labor	2011	529,930						8
9	A/C chiller	2011	75,594						9
10	Water Heater	2011	6,875						10
11	Sprinkler Heads	2011	7,157						11
12									12
13	Facility Remodel: Flooring, Paint, lighting & labor	2012	315,942						13
14	Therapy Sewer line	2012	13,193						14
15	Lighting Upgrade	2012	2,647						15
16									16
17	Elevator Door Restrictor	2013	6,150						17
18	Hot Water Pump	2013	3,216						18
19	Storage Tank Installation	2013	7,164						19
20	Boiler Replacement	2013	106,562						20
21	Sanitary Sewer Repair	2013	13,250						21
22	Water Heater	2013	3,770						22
23									23
24	Install Split System - Therapy Room	2014	6,089						24
25	Install New Windows	2014	30,700						25
26									26
27	Install electronic security - (6) doors	2015	37,697						27
28	Replace fire sprinkler system	2015	180,553						28
29	Install new water heater; disconnect and remove old heater	2015	6,398						29
30									30
31	Replace fire alarm control panel	2016	5,088						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,041,389	$ 167,450		$ 167,450	$	$	34

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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	$ 573,259	$ 46,279	$ 46,279	$		$	71
72	Current Year Purchases	4,553						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 577,812	$ 46,279	$ 46,279	$		$	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		2009 Turtletop bus	2008	$ 60,815	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 60,815	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,705,016	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 213,729	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,729	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 Minonk # 0048058 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: $ 19,087 Description: Televisions and copiers
(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.

Facility Name & ID Number Heritage Health Minonk # 0048058 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.

Facility Name & ID Number Heritage Health Minonk

STATE OF ILLINOIS
0048058 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$		$ 208,419	$		$ 208,419	1
2	Licensed Speech and Language Development Therapist		hrs			49,490			49,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			196,396	1,481		197,877	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				266,819		266,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					30,988			30,988	13
14	TOTAL			$		$ 485,293	$ 268,300		$ 753,593	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.

Facility Name & ID Number Heritage Health Minonk **#** 0048058 **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	$ 446	$	1
2	Cash-Patient Deposits	4,109		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	411,710		3
4	Supply Inventory (priced at)	(149)		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,213		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,042,257)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (604,928)	$	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)**	$ (604,928)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,154	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,109		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,966		30
31	Accrued Taxes Payable (excluding real estate taxes)	969		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	9,682		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 272,880	$	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)**	$ 272,880	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (877,808)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (604,928)	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Minonk **#** 0048058 **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**	$ (845,612)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (845,612)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,196)	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)**	$ (32,196)	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)**	$ (877,808)	24 *

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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	$ 3,246,065	1
2	Discounts and Allowances for all Levels	(1,639,263)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,606,802	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,578,486	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,578,486	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		12
13	Barber and Beauty Care	2,451	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	498,317	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,897	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 516,665	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27	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)**	$ 3,701,980	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	644,487	31
32	Health Care	1,492,674	32
33	General Administration	785,870	33
	B. Capital Expense		
34	Ownership	356,697	34
	C. Ancillary Expense		
35	Special Cost Centers	454,448	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)***	$ 3,734,176	40
41	**Income before Income Taxes (line 30 minus line 40)****	(32,196)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (32,196)	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 Minonk # 0048058 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,723	1,814	$ 59,062	$ 32.56	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,082	8,507	278,782	32.77	3
4	Licensed Practical Nurses	5,291	5,569	147,967	26.57	4
5	CNAs & Orderlies	30,626	32,238	454,259	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,604	3,794	67,189	17.71	8
9	Activity Director					9
10	Activity Assistants	5,474	5,762	70,043	12.16	10
11	Social Service Workers	1,939	2,041	52,488	25.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,560	15,326	181,572	11.85	15
16	Dishwashers					16
17	Maintenance Workers	4,846	5,101	73,163	14.34	17
18	Housekeepers	4,656	4,901	49,953	10.19	18
19	Laundry	3,467	3,650	35,251	9.66	19
20	Administrator	1,984	2,088	89,530	42.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,381	5,664	139,213	24.58	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)	91,633	96,455	$ 1,698,472 *	$ 17.61	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		1,162		36
37	Medical Records Consultant		2,000		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,530		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,370		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 8,062		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Minonk # 0048058 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Seaman			$ 89,530
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,530

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt services	$ 156,469
ADP	Payroll Tax Processing	1,198
Tango Inc	ACA Compliance	470
McKee Environmental	Inspections	510
Legal adj to Zero		2,657
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 161,304

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,853
Unemployment Compensation Insurance	17,804
FICA Taxes	129,933
Employee Health Insurance	71,808
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	6,706
Central Office Allocation	29,682
TOTAL (agree to Schedule V, line 22, col.8)	$ 279,786

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,371
Health Care Worker Background Check	
(Indicate # of checks performed)	509
PR	5,674
Dues & Subscriptions	6,002
License & Fees	4,935
Central Office Allocation	7,188
Less: Public Relations Expense	(5,674)
Non-allowable advertising	(2,674)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,331

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,235
	0
Seminar Expense	1,656
	(892)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Minonk # 0048058 Report Period Beginning: 01/01/16 Ending: 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 politica
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 **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
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 Departmen
during this cost report period. $ **91,188**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **1,015**

(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 fo
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
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	446							1,009	1,009	CASH	446
1010			CASH IN BANK								1,100	1,100	ACCTS RI	444,824
1040			CASH IN BANK-PAYROLL								1,101	1,101	ALLOW. I	(33,114)
1100			ACCOUNTS RECEIVABLE	411,710							1,110	1,110	ACCTS RECEIV-M/C	
1110			MEDICARE RECEIVABLES								1,125	1,125	ACCTS RECEIV-IPA	
1125			IPA INCOME RECEIVABLE								1,135	1,135	ACCTS RECEIV-IC	
1130			MEDICARE COST REPORT								1,140	1,140	UNAPPLIED CASH RECEIPTS	
1135			ACCOUNTS RECEIVABLE-IC								1,145	1,145	A/R SUSPENSE-REFUNDS	
1140			UNAPPLIED CASH RECEIPTS								1,200	1,200	PREPAID	21,213
1145			A/R SUSPENSE-REFUNDS								1,220	1,220	OTHER PREPAID EXPENSES	
1190			ACCRUED INTEREST REC								1,300	1,300	DIETARY INVENTORY	
1200			PREPAID INSURANCE	21,213							1,310	1,310	SUPPLIES	(149)
1220			OTHER PREPAID EXPENSES								1,320	1,320	LINEN INVENTORY	
1300			FOOD INVENTORY								1,409	1,409	LAND	0
1310			SUPPLIES INVENTORY	-149							1,450	1,450	FURNITU	0
1409			LAND	0							1,460			0
1450			FURNITURE & EQUIPMENT	0							1,475	1,475	BUILDIN	0
1460			ACCUM DEPR-FURN & EQUI	0							1,490	1,490	ACCUM I	0
1475			BUILDING & IMPROVEMENT	0							1,530	1,530	RESIDEN	4,109
1490			ACCUM DEPR-BUILDING	0							1,550	1,550	LOAN FE	0
1530			RESIDENT FUNDS	4,109							1,551	1,551	LOAN FEES ADDED	
1550			LOAN FEES	0							1,850	1,850	INTERCO	(1,042,257)
1560			REAL ESTATE TAX ESCROW								2,010	2,010	ACCOUN	(84,154)
1575			REIMBURSABLE PURCHASES								2,100	2,095	BONUSES PAYABLE	
1850			INTRACOMPANY	-1,042,257							2,100	2,100	ACCRUEI	(67,313)
2010			ACCOUNTS PAYABLE	-84,154							2,100	2,100	PR CLEAI	0
2095			BONUSES PAYABLE								2,100	2,100	PR CLEARING-LABOR	
2100			ACCRUED PAYROLL	-67,313							2,110	2,110	ACCRUEI	(106,653)
2110			ACCRUED VACATION PAY	-106,653							2,120	2,120	U.C. TAX	0
2120			UC TAXES PAYABLE								2,125	2,125	FICA TAX	(969)
2125			FICA TAX PAYABLE	-969	-969						2,130	2,130	FEDERAL W/H TAX PAYABLE	
2130			FIT PAYABLE								2,140	2,140	STATE W/H TAX PAYABLE	
2140			STATE W/H PAYABLE		0						2,152	2,152	WORKERS COMP ACCRUAL	
2145			EARNED INCOME CREDIT								2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2150			UC FED CREDIT REDUCTION								2,230	2,230	PAYROLL SAVINGS	
2230			PAYROLL SAVINGS								2,235	2,240	UNITED FUND	
2235			IRA W/HOLDINGS								2,240	2,246	GROUP INSURANCE - CAFETERIA	
2240			UNITED WAY								2,246	2,250	401K W/H	
2245			GROUP INSURANCE PAYABLE								2,250			
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260	WAGE GA	0
2260			WAGE GARNISHMENTS								2,300	2,300	ACCRUEI	0
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320	IPA PAYN	(9,682)
2300			ACCRUED INTEREST PAYAI	0							2,350	2,350	REAL EST	0
2310			SALES TAX PAYABLE								2,385			0
2320			IPA PAYMENTS PAYABLE	-9,682							2,400	2,400	CURRENT PORTION OF LT DEBT	
2350			REAL ESTATE TAX PAYABL	0							2,512	2,512	DUE TO F	(4,109)
2385			ACTIVITY FUND	0							2,600	2,600	LASALLE	0
2390			SECURITY DEPOSITS	0							2,600			
2391			VOLUNTEER FUND								2,625	2,625	LASALLE CONSTR. LOAN #2	
2393			HEART FUND/BAZAAR								2,625			
2395			DEFERRED INC EMP & MEM								2,695	2,695	CURRENT PORTION OF LT DEBT	
2400			CURRENT PORTION LT DEBT								2,720	2,720	RETAINE	845,612
2460			INCOME TAXES PAYABLE										net income	32,196
2512			DUE TO RESIDENTS	-4,109										
2600			MORTGAGE PAYABLE	0										
2650			EQUIPMENT LOAN PAYABLE										balance	0
2695			CURRENT PORTION LT DEBT											
2696			DEFERRED INCOME TAXES											
2710			COMMON STOCK											
2720			RETAINED EARNINGS	845,612										
2970			PROFIT/LOSS FOR PERIOD	32,196										
3007.1			PATIENT DAYS-PRIVATE	5,358							3,007	3,007	PATIENT DA	5,358
3007.2			PATIENT DAYS-IPA	4,529							3,007	3,007	PATIENT DA	4,529
3007.3			PATIENT DAYS-MEDICARE	2,531							3,007	3,007	PATIENT DA	2,531
3007.4			PATIENT DAYS-CONVERSION								3,007			0
3007.5			PATIENT DAYS-LICENSED								3,007			
3007.6			PATIENT DAYS-TOTAL								3,007			
3010		1	BASIC CHARGE-PRIVATE &	-3,213,730		0	0	0	0		3,007			
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3,010	3,010	BASIC CHAR	(3,213,730)
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		3,020	3,020	BASIC CHAR	0
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		3,030	3,030	BASIC CHAR	0
3035		4	DAY CARE/HOME CARE			0	0	0	0		3,040			64,287
3040		1	LIGHT NURSING CARE			0	0	0	0		3,050			0
3050		1	MEDIUM NURSING CARE			0	0	0	0		3,060			0
3060		1	HEAVY NURSING CARE			0	0	0	0		3,061			0
3061		1	SKILLED NURSING CARE								3,080	3,080	NURSING SU	(28,304)
3080		1	NURSING SUPPLIES-PRIVAT	-28,304		0	0	0	0		3,081	3,081	NURSING SU	0
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3,082	3,082	NURSING SU	0
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3,083	3,083	NURSING SU	0
3083		1	NURSING SUPPLIES MED PT B								3,100	3,100	DRUGS-MED	(498,317)
3100		17	DRUGS	-498,317		0	0	0	0		3,101			0
3101		17	DRUGS-OTHER								3,110	3,110	PHYSICAL TI	(1,578,486)
3110		6	PT-PRIVATE	-1,578,486		0	0	0	0		3,111			0
3111		6	PT-IPA			0	0	0	0		3,112	3,112	PHYSICAL TI	0
3112		6	PT-MEDICARE PART A			0	0	0	0		3,113	3,113	PHYSICAL TI	0
3113		6	PT-MEDICARE PART B			0	0	0	0		3,140	3,140	LABORATORY INCOME	
3130		1	PUBLIC AID ASSESSMENT II	64,287							3,150			0
3140		19	LABORATORY INCOME			0	0	0	0		3,151			
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3,152	3,152	ST/OT THERA	0
3151		6	SPEECH/OT-IPA			0	0	0	0		3,153	3,153	ST/OT THERA	0
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3153		6	SPEECH/OT MED PART B								3,410	3,410	IPA/OTHER D	0
3410		2	IPA DISCOUNTS	1,639,263		0	0	0	0		3,411	3,411	MEDICARE F	0
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3,420	3,420	MEDICARE D	1,595,307
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3,500			
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3,520	3,520	RENT INCOM	0
3520		16	RENT INCOME	0		6	0	6	0		3,530	3,530	BEAUTY SHO	(2,451)
3530		13	BEAUTY SHOP	-2,451		0	0	0	0		3,560			0
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		3,570	3,570		
3570		12	VENDING INCOME/EXPENSI	0		0	0	0	0		3,590	3,590	EQUIPMENT	(4,031)
3580		12	MANAGEMENT FEES			0	0	0	0		3,595	3,595	RESIDENT TI	(15,847)
3590		1	EQUIPMENT RENTAL	-4,031		0	0	0	0		3,600	3,600	MISC INCOM	(50)
3595		21	RESIDENT TRANSPORTATIC	-15,847		0	0	0	0		4,110	4,110	G&A WAGES	125,131
3600		21	MISC INCOME	-50		0	0	0	0		4,111	4,111	ADMINISTRA	89,530
4110			GENERAL & ADMINIST WAC	125,131	139,213	21	1	17	0		4,115	4,115	G&A PTO & I	14,082
4111			ADMINISTRATOR WAGES	89,530	89,530	17	1	0	0		4,120	4,120	EMPLOYEE I	6,809
4115			VACATION & SICK - G&A	14,082		21	1	0	0		4,121			
4120	4475		EMPLOYEE BENEFITS	6,706	250,104	22	3	0	0		4,130	4,130	EMPLOYEE S	0
4125			EMPLOYEE HEPETITIS VACI	0		22	3	0	0		4,135	4,135	EMPLOYEE S	0
4130			EMPLOYEE SCHOLORSHIP V	0	64,287	21	1	0	0		4,250	4,250	OFFICE SUPI	4,949
4135			EMPLOYEE SCHOLORSHIP C	0		23	3	0	0		4,255	4,255	POSTAGE	1,184
4220			DIRECTORS FEES	0	0	18	3	0	0		4,260	4,260	TELEPHONE	6,174
4250	4255		OFFICE SUPPLIES	14,107	14,107	21	2	0	0		4,275	4,275	TRAINING &	4,869
4260			TELEPHONE	6,174	6,174	21	3	0	0		4,276			
4275			TRAINING & EMPLOYEE DE	4,869	4,869	23	3	16	0	**	4,280	4,280	GENERAL TF	4,235
4280			GENERAL TRAVEL	4,235	5,891	24	3	16	0		4,281	4,281	MEAL EXPEI	0
4281			MEAL EXPENSE FOR TRAVE	0		24	3	19	0		4,285	4,285	EDUCATION	1,656
4285			EDUCATION & SEMINAR	1,656		24	3	19	-5,591	***	4,289	4,289	MEETINGS E	0
4290			HELP WANTED ADVERTISIN	1,371	54,618	20	3	0	0	-26,901	4,290	4,290	HELP WANTI	1,371
4291			PROMOTIONAL ADVERTISII	9,226		20	3	25	-9,226		4,291	4,291	PROMOTION	9,226
4292			PUBLIC RELATIONS	5,674		20	3	25	-5,674		4,292	4,292	PUBLIC RELA	5,674
4300			LICENSES & FEES	31,836		20	3	17	0		4,300	4,300	LICENSE & F	31,836
4310			DUES & SUBSCRIPTIONS	6,002		20	3	17	-2,674		4,310	4,310	DUES & SUB	6,002
4320			CONTRIBUTIONS	274		27	3	20	-274		4,320	4,320	CONTRIBUTI	274
4350			PROFESSIONAL FEES	4,835	161,304	19	3	22	-2,657		4,350	4,350	PROFESSION	4,835
4355			MEDICAL DIRECTOR	1,162	1,162	9	3	0	0		4,355	4,355	MEDICAL DI	1,162
4360			UTILIZATION REVIEW	0		10	3	0	0		4,362			2,000
4361			OTHER PHYSICIAN FEES			39	3	0	0		4,363			2,530
4362			MEDICAL RECORDS CONSU	2,000		10	3	0	0		4,364	4,364	SOCIAL SERV	2,370
4363			PHARMACIST FEES	2,530		10	3	0	0		4,370	4,370	TV RENTAL	16,868
4364			SOC SERV/ACT CONSULT	2,370	2,370	12	3	0	0		4,383	4,383	BACKGROUI	509
4370			TV RENTAL	16,868		35	3	5	0		4,390	4,390	OTHER TAXI	0
4380			INCOME TAXES		-33,161	27	3	26	0		4,400	4,400	PAYROLL TA	138,444
4383			BACKGROUND CHECKS	509		20	3	26	0		4,401	4,401	PAYROLL TA	9,293
4400			PAYROLL TAXES	138,444		22	3	0	0		4,410	4,410	GROUP INSU	71,808
4401			PAYROLL TAXES ADMINIST	9,293		22	3	0	0		4,420	4,420	LIABILITY IN	28,934
4410			GROUP INSURANCE	71,808		22	3	0	0		4,430	4,430	WORKMAN'S	23,379
4420			LIABILITY INSURANCE	28,934	28,934	26	3	0	0		4,435	4,435	W/C-FIRST A	0
4425			INSURANCE-OWNERS			22	3	21	0		4,436	4,436	DRUG TESTI	474
4430			WORKMENS COMP INSURAI	23,853		22	3	0	0		4,450	4,450	MANAGEME	156,469
4450			CENTRAL OFFICE FEES	156,469		19	3	34	0	**	4,460	4,460	BAD DEBTS	(33,435)
4460			BAD DEBTS	-33,435		27	3	24	33,435		4,461	4,461	BAD DEBTS	43,956
4470			LOST ITEMS-RESIDENTS	0		27	3	0			4,470	4,470	LOST ITEMS-	0
4490			MISCELLANEOUS	0		27	3	0	0		4,475	4,475	UNIFORM EX	(103)
4510			REAL ESTATE TAXES	0	0	33	3	0	0		4,486	4,486	M.I.S. Softwar	21,874
4600			LEASED EQUIPMENT	2,219	19,087	35	3	16	0		4,490	4,490	MISC EXPEN	197
5110			MAINTENANCE SALARIES	66,942	73,163	6	1	0	0		4,496	4,496	MISC. M.I.S. I	7,974
5120			MAINTENANCE SICK & VAC	6,221		6	1	0	0		4,510	4,510	REAL ESTAT	0
5130			ELECTRIC	32,832	63,713	5	3	0	0		4,600	4,600	LEASED EQU	2,219
5131			NATURAL GAS	11,194		5	3	0	0		5,110	5,110	MAINTENAN	66,942
5132			HEATING & DEISEL OIL			5	3	0	0		5,120	5,120	MAINTENAN	6,221
5133			WATER & SEWER	19,687		5	3	0	0		5,130	5,130	ELECTRIC	32,832
5134			TRASH COLLECTION	5,326	40,380	6	3	0	0		5,131	5,131	NATURAL G.	11,194
5140			PROPERTY PLANT REPLACI	16,772	45,053	6	2	0	0		5,133	5,133	WATER & SE	19,687
5160			GENERAL REPAIR & MAINT	28,281		6	2	0	0		5,134	5,134	TRASH COLI	5,326
5165			MAINTENANCE CONTRACT	35,054		6	3	0	0		5,140	5,140	PROP/PLANT	16,772
5210			DIETARY WAGES	167,944	181,572	1	1	0	0		5,160	5,160	GENERAL RI	28,281
5220			DIETARY SICK & VAC	13,628		1	1	0	0		5,165	5,165	MAINTENAN	13,180
5240			SALES TAX			2	3	13	0		5,210	5,210	DIETARY WA	167,944
5248			FOOD PURCHASES	125,367	124,352	2	2	0	0		5,220	5,220	DIETARY PT	13,628
5250			SUPPLIES-DISHWASHING	2,737	10,462	1	2	0	0		5,248	5,248	FOOD PURCI	125,170
5260			DIETARY REPLACEMENT	1,506		1	2	0	0		5,250	5,250	SUPPLIES DI	2,737
5270			KITCHEN SUPPLIES-PAPER	6,219		1	2	0	0		5,260	5,260	REPLACEME	1,506
5295			MEAL CREDIT	-1,015		2	2	0	0		5,270	5,270	KITCHEN SU	6,219
5310			LAUNDRY WAGES	33,001	35,251	4	1	0	0		5,295	5,295	MEAL INCOI	(1,015)
5340			LAUNDRY SICK & VAC	2,250		4	1	0	0		5,310	5,310	LAUNDRY W	33,001
5370			LAUNDRY REPLACEMENT	2,117	4,903	4	2	0	0		5,340	5,340	LAUNDRY P	2,250
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		5,370	5,370	REPLACEME	2,117
5390			LAUNDRY SUPPLIES	2,786		4	2	0	0		5,380			68
5410			HOUSEKEEPING WAGES	45,294	49,953	3	1	0	0		5,390	5,390	SUPPLIES	2,718
5440			HOUSEKEEPING SICK & VAI	4,659		3	1	0	0		5,410	5,410	HOUSEKEEP	45,294
5480			HOUSEKEEPING SUPPLIES	15,685	15,685	3	2	0	0		5,440	5,440	HOUSEKEEP	4,659
5490			HOUSEKEEPING SUPPLIES-I	0		3	2	0	0		5,480	5,480	SUPPLIES-CI	15,685
6010			RN WAGES-MEDICARE		1,007,259	10	1	0	0		5,490	5,490	SUPPLIES-HC	0
6020			RN WAGES-NON MEDICARE	253,701		10	1	0	0		6,020	6,020	RN WAGES	253,701
6030			DON WAGES	59,062		10	1	0	0		6,030	6,030	DON WAGES	59,062
6035			ADON	0		10	1	0	0		6,035	6,035	ADON WAGI	0
6040			RN SICK & VACATION	25,081		10	1	0	0		6,040	6,040	RN PTO & RE	25,081
6110			LPN WAGES-MEDICARE	132,862		10	1	0	0		6,120	6,120	LPN WAGES	132,862
6120			LPN WAGES-NON MEDICAR	0		10	1	0	0		6,140	6,140	LPN PTO & R	15,105
6130			LPN WAGES OTHER			10	1	0	0		6,220	6,220	AIDES WAGI	420,582
6140			LPN SICK & VACATION	15,105		10	1	0	0		6,240	6,240	AIDES PTO &	33,677
6210			AIDE WAGES-MEDICARE			10	1	0	0		6,245			
6220			AIDE WAGES-NON MEDICAI	420,582		10	1	0	0		6,246			
6230			WARD CLERKS			10	1	0	0		6,247			
6240			AIDE VACATION & SICK	33,677		10	1	0	0		6,250			0
6245			CONTRACT NURSES-RN	0		10	3	0	0		6,255			0
6246			CONTRACT NURSES-LPN	0		10	3	0	0		6,260			0
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		6,270	6,270	REHAB WAG	58,489
6250			NURSE AIDE TRAINING WAI	0	0	13	1	0	0		6,275	6,275	REHAB PTO	8,700
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0		6,290	6,290	NURSING SU	46,184
6260			NURSE AIDE TRAINING REII	0		0	0	0	0		6,295	6,295	NURSING SU	157
6270			REHAB WAGES	58,489		10	1	0	0		6,390	6,390	REPLACEME	1,473
6275			REHAB SICK & VAC	8,700		10	1	0	0		6,490	6,490	OTHER	611
6280			NURSING DEPT EDUCATION			23	3	0	0		7,280	7,280	DRUG PURCI	127,699
6290			NURSING SUPPLIES	46,184	47,814	10	2	0	0		7,281	7,281	DRUG PURCI	139,120
6295			NURSING SUPPLIES	157		10	2	0	0		7,380	7,380	LABORATOF	21,646
6390			REPLACEMENT-NURSING	1,473		10	2	0	0		7,391	7,390	X-RAY SERV	9,342
6490			NURSING OTHER	611	5,141	10	3	0	0		7,393			
7280			DRUG PURCHASES	127,699	268,300	39	2	0	0	***	7,510	7,510	ACTIVITIES	64,982
7281			DRUG PURCHASES-OTHER	139,120		39	2				7,540	7,540	ACTIVITIES	5,061
7380			LABORATORY SERVICES	30,988	30,988	39	3	0	0		7,590	7,590	ACTIVITIES	7,109
7410			HOME HEALTH SALARY			39	1	0	0		7,620	7,620	PHYSICAL TI	196,396
7440			HOME HEALTH SICK & VAC			39	1	0	0		7,660	7,660	P.T. SUPPLY	1,481
7450			HOME HEALTH EXPENSES			39	3	0	0		7,710	7,710	SOCIAL SERV	49,889
7510			ACTIVITES WAGES	64,982	70,043	11	1	0	0		7,720	7,720	SOCIAL SERV	2,599
7540			ACTIVITIES SICK & VAC	5,061		11	1	0	0		7,730	7,730	SOCIAL SERVICE-EXPENSES	
7590			ACTIVITIES SUPPLIES	7,109	7,109	11	2	0	0		7,740	7,740	OCCUPATIOI	208,419
7595			ACTIVITIES FEES	0	0	11	3	0	0		7,750			0
7610			PT WAGES			39	1	0	0		7,770	7,770	SPEECH THE	49,490
7611			PT SICK & VACATION			39	1	0	0		7,820	7,820	BEAUTICIAN	143
7620			PT FEES	196,396	454,305	39	3	0	0	***	7,890			0
7660			PT SUPPLIES	1,481		39	2	0	0		7,960			0
7710			SOCIAL SERVICE WAGES	49,889	52,488	12	1	0	0		8,120	8,120	INTEREST	0
7720			SOCIAL SERVICE SICK & VA	2,599		12	1	0	0		8,125			22,250
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		8,130	8,130	DEPRECIATI	0
7740			OT FEE	208,419		39	3	0	0	***	8,150			0
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510	9,510	INTEREST IN	(27)
7770			SPEECH THERAPY FEE	49,490		39	3	0	0	***	9,520	9,520	MISC NON-O	0
7800			BEAUTICIAN WAGES		0	40	1	0	0		9,530	4,220		0
7810			BEAUTICIAN SICK & VAC			40	1	0	0			8,100		315,360
7820			BEAUTICIAN FEES	143	143	40	3	0	0			9,702		0
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0			5,230		0
7910			VOLUNTEER COORDINATOR			21	1	0	0					32,196
7940			VOL COORD SICK & VAC			21	1	0	0					
7960			VOL COORD SUPPLIES	0		21	2	0	0					
8100			RENT	315,360	315,360	34	3	0	0				Expenses Fixed Assets	
8120			INTEREST EXPENSE	22,250	22,250	32	3	14	-27					0
8130			DEPRECIATION	0	0	30	3	9	0					
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0				
9510			INTEREST INCOME	-27		32	0	10	0					
9520			MISC NON-OPERATING INC(	0		0	0	0	0					
9700			INCOME TAXES	0		0	0	0	0					
				3,669,862	3,734,176									
					64,314									
GRAND TOTALS				32,196					7,312					
				(NET INCOME)										
				0										

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	5,358	5,358
IPA	4,529	4,529
medicare	2,531	2,531
		12,418

Heritage Manor Minonk
HFS ID# 203903980001
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	(26,901)
Provider Assesment Fee - $6.07	Line 20, Col 3	(64,287)
		(91,188)
Provider Participation Fee	Line 42	91,188
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(266,819)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(30,988)
		(297,807)
Ancillary Service Centers	Line 39	297,807