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: 0048074

Facility Name: Heritage Health Mt Zion

Address: 1225 Woodland Drive (Number) Mt Zion (City) 62549 (Zip Code)

County: Macon

Telephone Number: 217 864-2356 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2007

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 Mt Zion # 0048074 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	15,212	6,648	2,735	24,595	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,212	6,648	2,735	24,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.60%

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 July 2007

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 2,735

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 Mt Zion # 0048074 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	174,252	16,607		190,859		190,859	3,923	194,782			1
2	Food Purchase		188,973		188,973		188,973		188,973			2
3	Housekeeping	62,309	23,252		85,561		85,561	28	85,589			3
4	Laundry	97,814	8,411		106,225		106,225		106,225			4
5	Heat and Other Utilities			110,795	110,795		110,795	1,219	112,014			5
6	Maintenance	66,618	46,289	51,197	164,104		164,104	16,415	180,519			6
7	Other (specify):*											7
8	TOTAL General Services	400,993	283,532	161,992	846,517		846,517	21,585	868,102			8
	B. Health Care and Programs											
9	Medical Director			22,680	22,680		22,680		22,680			9
10	Nursing and Medical Records	1,392,018	130,983	119,993	1,642,994		1,642,994	(22,384)	1,620,610			10
10a	Therapy		494,070	9,189	503,259	(503,072)	187		187			10a
11	Activities	71,552	1,848		73,400		73,400		73,400			11
12	Social Services	47,869		5,651	53,520		53,520		53,520			12
13	CNA Training							966	966			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,511,439	626,901	157,513	2,295,853	(503,072)	1,792,781	(21,418)	1,771,363			16
	C. General Administration											
17	Administrative	92,232			92,232		92,232		92,232			17
18	Directors Fees											18
19	Professional Services			222,816	222,816		222,816	(205,930)	16,886			19
20	Dues, Fees, Subscriptions & Promotions			196,618	196,618	(176,609)	20,009	(1,628)	18,381			20
21	Clerical & General Office Expenses	152,763	17,324	6,997	177,084		177,084	229,103	406,187			21
22	Employee Benefits & Payroll Taxes			385,813	385,813		385,813	23,867	409,680			22
23	Inservice Training & Education			6,619	6,619		6,619	948	7,567			23
24	Travel and Seminar			5,600	5,600		5,600	(601)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,646	37,646		37,646	12,970	50,616			26
27	Other (specify):*			164,335	164,335		164,335	(164,335)				27
28	TOTAL General Administration	244,995	17,324	1,026,444	1,288,763	(176,609)	1,112,154	(105,606)	1,006,548			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,157,427	927,757	1,345,949	4,431,133	(679,681)	3,751,452	(105,439)	3,646,013			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Health Mt Zion #0048074 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							180,061	180,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,053	34,053		34,053	48,226	82,279			32
33	Real Estate Taxes							64,686	64,686			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,867)	4,633			34
35	Rent-Equipment & Vehicles			7,415	7,415		7,415	6,983	14,398			35
36	Other (specify):*											36
37	TOTAL Ownership			369,968	369,968		369,968	(23,911)	346,057			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			610,636	610,636	503,072	1,113,708	(104,324)	1,009,384			39
40	Barber and Beauty Shops			18,082	18,082		18,082		18,082			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					176,609	176,609		176,609			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			628,718	628,718	679,681	1,308,399	(104,324)	1,204,075			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,157,427	927,757	2,344,635	5,429,819		5,429,819	(233,674)	5,196,145			45

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	(1,096)			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	(7,052)			18
19	Entertainment	(5,495)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,413)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,335)			24
25	Fund Raising, Advertising and Promotional	(9,116)			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)**	$ (190,507)		$	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)	(43,167)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (43,167)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (233,674)		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 Mt Zion

ID# 0048074

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		(3,413)	19	22
23				23
24		(164,335)	27	24
25		(9,116)	20	25
26				26
27		(7,052)	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**	(183,916)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	3,923	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	(22,625)	241	0	0	0	0	0	0	0	0	(22,384)	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	(22,625)	1,207	0	0	0	0	0	0	0	0	(21,418)	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	(3,413)	(217,558)	15,041	0	0	0	0	0	0	0	0	(205,930)	19
20	Fees, Subscriptions & Promotions	(9,116)	0	7,488	0	0	0	0	0	0	0	0	(1,628)	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	(7,052)	0	30,919	0	0	0	0	0	0	0	0	23,867	22
23	Inservice Training & Education	0	0	948	0	0	0	0	0	0	0	0	948	23
24	Travel and Seminar	(5,495)	0	4,894	0	0	0	0	0	0	0	0	(601)	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):*	(164,335)	0	0	0	0	0	0	0	0	0	0	(164,335)	27
28	**TOTAL General Administration**	(189,411)	(217,558)	301,363	0	0	0	0	0	0	0	0	(105,606)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(189,411)	(240,183)	324,155	0	0	0	0	0	0	0	0	(105,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mt Zion # 0048074 **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	158,729	0	21,332	0	0	0	0	0	0	0	180,061	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,096)	49,093	0	229	0	0	0	0	0	0	0	48,226	32
33	Real Estate Taxes	0	64,686	0	0	0	0	0	0	0	0	0	64,686	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**	(1,096)	(55,992)	0	33,177	0	0	0	0	0	0	0	(23,911)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(104,324)	0	0	0	0	0	0	0	0	0	(104,324)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(104,324)	0	0	0	0	0	0	0	0	0	(104,324)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(190,507)	(400,499)	324,155	33,177	0	0	0	0	0	0	0	(233,674)	45

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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%	$ (22,625)	$ (22,625)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(104,324)	(104,324)	3
4	V	19	Adjustment for Related Organization	217,558	Heritage Operations Group, LLC	0.00%		(217,558)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC	0.00%		(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		64,686	64,686	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,370	46,370	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		158,729	158,729	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,723	2,723	10
11	V								11
12	V								12
13	V								13
14	Total			$ 546,058			$ 145,559	$ * (400,499)	14

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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		$	$ 3,923	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 Mt Zion # 0048074 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					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 Mt Zion # 0048074 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 Mt Zion # 0048074 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	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 Mt Zion # 0048074 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	$	$	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 Mt Zion # 0048074 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		x	Mortgage			$	$			$ 46,370	1
2	Bank of America		x	Loan Fee Amortization							2,723	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						$	$			$ 83,146	9
	B. Non-Facility Related*											
10	Interest Income										(1,096)	10
11												11
12	Allocated Corporate										229	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (867)	14
15	TOTALS (line 9+line14)						$	$			$ 82,279	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 Mt Zion # 0048074 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.)		$ 64,686	2
3. Under or (over) accrual (line 2 minus line 1).		$ 64,686	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.		$ 64,686	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	60,228	8
	2012	61,050	9
	2013	61,882	10
	2014	62,358	11
	2015	64,686	12

FOR BHF USE ONLY

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

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Mt Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0048074

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.	121704210003		$ 64,686.16	$ 64,686.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 64,686.16	$ 64,686.00

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 Mt Zion # 0048074 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,920 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				$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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				$ 1,076,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Environmental Site Study			1998	1,662						9
10	Sign			1998	1,860						10
11	Air conditioning Unit			1999	5,732						11
12	Air Conditioner			1999	750						12
13	Professional Fees --Remodeling Project			1999	15,922						13
14											14
15	Facility Remodel -- Materials			2000	241,637						15
16	Professional Fees --Remodeling Project			2000	58,519						16
17	Kitchen A/C			2000	990						17
18	Fire Alarm			2000	1,997						18
19	Door Guard System			2000	3,444						19
20											20
21	Smoke Detectors			2001	3,775						21
22	Water Main Break			2001	3,426						22
23	Commercial Disposer			2001	757						23
24	Heat Pump			2001	5,158						24
25	Carpet Extract			2001	1,206						25
26				2001							26
27	Facility Remodel -- Contractor			2001	1,397,646						27
28	Professional Fees --Remodeling Project			2001	45,077						28
29											29
30	Facility Remodel -- Contractor			2002	2,762						30
31	Fire Dampers			2002	2,766						31
32											32
33	C/O Allocation					21,332		21,332			33
34	Book Depreciation					129,635		129,635			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 Mt Zion # 0048074 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	Asphalt Sealing	2003	$ 1,447	$		$	$	$	37
38	Sprinklers	2003	2,680						38
39	Storm Windows	2003	1,173						39
40									40
41	Water Heater	2004	1,114						41
42	Disposal	2004	871						42
43									43
44	A/C Laundry Room	2005	2,968						44
45									45
46	Sidewalk	2006	4,080						46
47	Parking Lot Sealcoat	2006	2,225						47
48	Dishroom rehab	2006	3,631						48
49	Oxygen storage room rehab	2006	3,858						49
50	Fire Alarm	2006	2,249						50
51									51
52									52
53									53
54									54
55	Storage Garage	2007	23,848						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58									58
59									59
60	Window Replacement	2009	56,034						60
61	HVAC	2009	2,656						61
62	HVAC rooftop	2009	9,250						62
63	Water Heater	2009	7,925						63
64	Parking Lot Sealcoat	2009	31,071						64
65									65
66	Water Heater	2010	16,232						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,056,165	$ 150,967		$ 150,967	$	$	70

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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		$ 3,056,165	$ 150,967		$ 150,967	$	$	1
2									2
3	Nurse Call & technology system	2011	184,918						3
4	Carpet	2011	9,016						4
5	Medcare lift	2011	8,334						5
6	Asbestos Abatement	2011	11,601						6
7	Heat Exchange	2011	5,637						7
8	Air Handler Unit	2011	4,714						8
9									9
10	Addison air unit	2012	2,940						10
11	Cast Iron Pipe	2012	3,208						11
12	Generator Control	2012	3,362						12
13	Nurse Call & technology system	2012	3,636						13
14									14
15	Flooring - Room 10	2013	3,173						15
16	Lighting Retrofit	2013	2,887						16
17									17
18	Install Replacement Split System - Laundry Room	2014	9,800						18
19	Schematic Design Fees - Facility Renovation Project	2014	8,428						19
20									20
21	Schematic Design Fees - Facility Renovation Project	2015	2,101						21
22	Install (8) six gallon electric water heaters	2015	6,930						22
23	Replace compressor on walk-in freezer	2015	3,843						23
24									24
25	No Improvements made in 2016								25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,330,693	$ 150,967		$ 150,967	$	$	34

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	$ 746,734	$ 29,094	$ 29,094	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 746,734	$ 29,094	$ 29,094	$		$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,127,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 180,061	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 Mt Zion # 0048074 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: $ 7,415 Description: Televisions and Office equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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 Mt Zion

STATE OF ILLINOIS
0048074 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	$		$ 295,831	$		$ 295,831	1
2	Licensed Speech and Language Development Therapist		hrs			43,509			43,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			271,296	187		271,483	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				493,883		493,883	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,189			9,189	13
14	TOTAL			$		$ 619,825	$ 494,070		$ 1,113,895	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 Mt Zion **#** 0048074 **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	$ 759	$	1
2	Cash-Patient Deposits	11,023		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,237,020		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,047		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(987,587)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 282,262	$	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)**	$ 282,262	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 195,247	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,023		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,812		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,410		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	21,482		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 378,974	$	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)**	$ 378,974	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (96,712)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 282,262	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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**	$ 117,698	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 117,698	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(214,410)	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)**	$ (214,410)	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)**	$ (96,712)	24 *

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	$ 4,493,389	1
2	Discounts and Allowances for all Levels	(2,059,452)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,433,937	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,827,870	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,827,870	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	19,129	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	933,119	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	258	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 952,506	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,096	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,096	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,215,409	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	846,517	31
32	Health Care	2,295,853	32
33	General Administration	1,288,763	33
	B. Capital Expense		
34	Ownership	369,968	34
	C. Ancillary Expense		
35	Special Cost Centers	628,718	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,429,819	40
41	**Income before Income Taxes (line 30 minus line 40)****	(214,410)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (214,410)	43

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

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

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

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

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	1,699	1,788	$ 62,846	$ 35.15	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,919	9,388	281,050	29.94	3
4	Licensed Practical Nurses	13,280	13,980	355,198	25.41	4
5	CNAs & Orderlies	46,467	48,914	643,672	13.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,716	1,806	49,252	27.27	8
9	Activity Director					9
10	Activity Assistants	4,534	4,773	71,552	14.99	10
11	Social Service Workers	1,725	1,816	47,869	26.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,164	14,909	174,252	11.69	15
16	Dishwashers					16
17	Maintenance Workers	3,276	3,448	66,618	19.32	17
18	Housekeepers	5,444	5,732	62,309	10.87	18
19	Laundry	6,450	6,789	97,814	14.41	19
20	Administrator	1,984	2,088	92,232	44.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,069	6,388	152,763	23.91	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)	115,727	121,819	$ 2,157,427 *	$ 17.71	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		22,680		36
37	Medical Records Consultant		1,880		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,482		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		5,651		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,693		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 27,507		50
51	Licensed Practical Nurses		14,728		51
52	Certified Nurse Assistants/Aides		70,981		52
53	TOTAL (lines 50 - 52)		$ 113,216		53

Facility Name & ID Number Heritage Health Mt Zion # 0048074 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Cassella			$ 92,232
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,232

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	$ 217,558
ADP	Payroll tax processing	1,242
Tango Inc.	ACA compliance	603
Legal adj to Zero		3,413
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 222,816

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,099
Unemployment Compensation Insurance	22,748
FICA Taxes	165,043
Employee Health Insurance	146,312
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	17,559
Central Office Allocation	30,919
TOTAL (agree to Schedule V, line 22, col.8)	$ 409,680

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	2,021
Health Care Worker Background Check	
(Indicate # of checks performed)	1,289
PR	5,548
Dues & Subscriptions	5,682
License & Fees	4,802
Central Office Allocation	7,488
Less: Public Relations Expense	(5,548)
Non-allowable advertising	(2,901)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,381

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,396
	0
Seminar Expense	1,204
	(601)
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 Mt Zion # 0048074 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 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 fo
Schedule VII)? YES NO 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. $ **176,609**
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. $ **1,670**

(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	759							
1010	CASH IN BANK								
1040	CASH IN BANK-PAYROLL								
1100	ACCOUNTS RECEIVABLE	1,237,020							
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	21,047							
1220	OTHER PREPAID EXPENSES								
1300	FOOD INVENTORY								
1310	SUPPLIES INVENTORY	0							
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	11,023							
1550	LOAN FEES	0							
1560	REAL ESTATE TAX ESCROW								
1575	REIMBURSABLE PURCHASES								
1850	INTRACOMPANY	-987,587							
2010	ACCOUNTS PAYABLE	-195,247							
2095	BONUSES PAYABLE								
2100	ACCRUED PAYROLL	-50,164							
2110	ACCRUED VACATION PAY	-96,648							
2120	UC TAXES PAYABLE								
2125	FICA TAX PAYABLE	-4,410	-4,410						
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	-21,482							
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	-11,023							
2600	MORTGAGE PAYABLE	0							
2650	EQUIPMENT LOAN PAYABLE								
2695	CURRENT PORTION LT DEBT								
2696	DEFERRED INCOME TAXES								
2710	COMMON STOCK								
2720	RETAINED EARNINGS	-117,698							
2970	PROFIT/LOSS FOR PERIOD	214,410							
3007.1	PATIENT DAYS-PRIVATE	6,648							
3007.2	PATIENT DAYS-IPA	15,212							
3007.3	PATIENT DAYS-MEDICARE	2,735							
3007.4	PATIENT DAYS-CONVERSION								
3007.5	PATIENT DAYS-LICENSED								
3007.6	PATIENT DAYS-TOTAL								
3010	1 BASIC CHARGE-PRIVATE &	-4,458,832		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		
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	-32,910		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	-933,119		0	0	0	0		
3101	17 DRUGS-OTHER								
3110	6 PT-PRIVATE	-1,827,870		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 I!	135,434							
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	2,059,452		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	3	6	0		
3530	13 BEAUTY SHOP	-19,129		0	0	0	0		
3560	12 ACTIVITY FUND INCOME	0		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	-1,647		0	0	0	0		
3595	21 RESIDENT TRANSPORTATIO	0		0	0	0	0		
3600	21 MISC INCOME	-258		0	0	0	0		
4110	GENERAL & ADMINIST WA(	142,910	152,763	21	1	17	0		
4111	ADMINISTRATOR WAGES	92,232	92,232	17	1	0	0		
4115	VACATION & SICK - G&A	9,853		21	1	0	0		
4120 4475	EMPLOYEE BENEFITS	8,742	385,813	22	3	0	0		
4125	EMPLOYEE HEPETITIS VAC(	0		22	3	0	0		
4130	EMPLOYEE SCHOLORSHIP V	5,969	135,434	21	1	0	0		
4135	EMPLOYEE SCHOLORSHIP (	2,848		23	3	0	0		
4220	DIRECTORS FEES	0	0	18	3	0	-7,052		
4250 4255	OFFICE SUPPLIES	17,324	17,324	21	2	0	0		
4260	TELEPHONE	6,997	6,997	21	3	0	0		
4275	TRAINING & EMPLOYEE DE	6,619	6,619	23	3	16	0	**	
4280	GENERAL TRAVEL	4,396	5,600	24	3	16	0		
4281	MEAL EXPENSE FOR TRAVE	0		24	3	19	0		
4285	EDUCATION & SEMINAR	1,204		24	3	19	-5,495	***	
4290	HELP WANTED ADVERTISIN	2,021	61,184	20	3	0	0		-41,175
4291	PROMOTIONAL ADVERTISI!	667		20	3	25	-667		
4292	PUBLIC RELATIONS	5,548		20	3	25	-5,548		
4300	LICENSES & FEES	45,977		20	3	17	0		
4310	DUES & SUBSCRIPTIONS	5,682		20	3	17	-2,901		
4320	CONTRIBUTIONS	0		27	3	20	0		
4350	PROFESSIONAL FEES	5,258	222,816	19	3	22	-3,413		
4355	MEDICAL DIRECTOR	22,680	22,680	9	3	0	0		
4360	UTILIZATION REVIEW	0		10	3	0	0		
4361	OTHER PHYSICIAN FEES			39	3	0	0		
4362	MEDICAL RECORDS CONSU	1,880		10	3	0	0		
4363	PHARMACIST FEES	4,482		10	3	0	0		
4364	SOC SERV/ACT CONSULT	5,651	5,651	12	3	0	0		
4370	TV RENTAL	6,335		35	3	5	0		
4380	INCOME TAXES		164,335	27	3	26	0		
4383	BACKGROUND CHECKS	1,289		20	3	26	0		
4400	PAYROLL TAXES	178,217		22	3	0	0		
4401	PAYROLL TAXES ADMINIST	9,574		22	3	0	0		
4410	GROUP INSURANCE	146,312		22	3	0	0		
4420	LIABILITY INSURANCE	37,646	37,646	26	3	0	0		
4425	INSURANCE-OWNERS			22	3	21	0		
4430	WORKMENS COMP INSURAI	27,099		22	3	0	0		
4450	CENTRAL OFFICE FEES	217,558		19	3	34	0	**	
4460	BAD DEBTS	164,335		27	3	24	-164,335		
4470	LOST ITEMS-RESIDENTS	0		27	3	0			
4490	MISCELLANEOUS	0		27	3	0	0		
4510	REAL ESTATE TAXES	0	0	33	3	0	0		
4600	LEASED EQUIPMENT	1,080	7,415	35	3	16	0		
5110	MAINTENANCE SALARIES	60,340	66,618	6	1	0	0		
5120	MAINTENANCE SICK & VAC	6,278		6	1	0	0		
5130	ELECTRIC	72,904	110,795	5	3	0	0		
5131	NATURAL GAS	5,272		5	3	0	0		
5132	HEATING & DEISEL OIL			5	3	0	0		
5133	WATER & SEWER	32,619		5	3	0	0		
5134	TRASH COLLECTION	4,423	51,197	6	3	0	0		
5140	PROPERTY PLANT REPLACI	4,319	46,289	6	2	0	0		
5160	GENERAL REPAIR & MAINT	41,970		6	2	0	0		
5165	MAINTENANCE CONTRACT	46,774		6	3	0	0		
5210	DIETARY WAGES	165,156	174,252	1	1	0	0		
5220	DIETARY SICK & VAC	9,096		1	1	0	0		
5240	SALES TAX			2	3	13	0		
5248	FOOD PURCHASES	190,643	188,973	2	2	0	0		
5250	SUPPLIES-DISHWASHING	2,920	16,607	1	2	0	0		
5260	DIETARY REPLACEMENT	2,989		1	2	0	0		
5270	KITCHEN SUPPLIES-PAPER	10,698		1	2	0	0		
5295	MEAL CREDIT	-1,670		2	2	0	0		
5310	LAUNDRY WAGES	82,232	97,814	4	1	0	0		
5340	LAUNDRY SICK & VAC	15,582		4	1	0	0		
5370	LAUNDRY REPLACEMENT	4,066	8,411	4	2	0	0		
5380	LAUNDRY REIMBURSEMENT			4	3	0	0		
5390	LAUNDRY SUPPLIES	4,345		4	2	0	0		
5410	HOUSEKEEPING WAGES	58,112	62,309	3	1	0	0		
5440	HOUSEKEEPING SICK & VA(	4,197		3	1	0	0		
5480	HOUSEKEEPING SUPPLIES	22,878	23,252	3	2	0	0		
5490	HOUSEKEEPING SUPPLIES-I	374		3	2	0	0		
6010	RN WAGES-MEDICARE		1,392,018	10	1	0	0		
6020	RN WAGES-NON MEDICARE	257,704		10	1	0	0		
6030	DON WAGES	62,846		10	1	0	0		
6035	ADON	0		10	1	0	0		
6040	RN SICK & VACATION	23,346		10	1	0	0		
6110	LPN WAGES-MEDICARE	332,574		10	1	0	0		
6120	LPN WAGES-NON MEDICAR	0		10	1	0	0		
6130	LPN WAGES OTHER			10	1	0	0		
6140	LPN SICK & VACATION	22,624		10	1	0	0		
6210	AIDE WAGES-MEDICARE			10	1	0	0		
6220	AIDE WAGES-NON MEDICAI	612,510		10	1	0	0		
6230	WARD CLERKS			10	1	0	0		
6240	AIDE VACATION & SICK	31,162		10	1	0	0		
6245	CONTRACT NURSES-RN	27,507		10	3	0	0		
6246	CONTRACT NURSES-LPN	14,728		10	3	0	0		
6247	CONTRACT NURSES-AIDES	70,981		10	3	0	0		
6250	NURSE AIDE TRAINING WA(	0	0	13	1	0	0		
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0		
6260	NURSE AIDE TRAINING REI	0		0	0	0	0		
6270	REHAB WAGES	46,419		10	1	0	0		
6275	REHAB SICK & VAC	2,833		10	1	0	0		
6280	NURSING DEPT EDUCATION			23	3	0	0		
6290	NURSING SUPPLIES	50,100	130,983	10	2	0	0		
6295	NURSING SUPPLIES	75,210		10	2	0	0		
6390	REPLACEMENT-NURSING	5,673		10	2	0	0		
6490	NURSING OTHER	415	119,993	10	3	0	0		
7280	DRUG PURCHASES	175,547	494,070	39	2	0	0	***	
7281	DRUG PURCHASES-OTHER	318,336		39	2				
7380	LABORATORY SERVICES	9,189	9,189	39	3	0	0		
7410	HOME HEALTH SALARY			39	1	0	0		
7440	HOME HEALTH SICK & VAC			39	1	0	0		
7450	HOME HEALTH EXPENSES			39	3	0	0		
7510	ACTIVITES WAGES	65,916	71,552	11	1	0	0		
7540	ACTIVITIES SICK & VAC	5,636		11	1	0	0		
7590	ACTIVITIES SUPPLIES	1,848	1,848	11	2	0	0		
7595	ACTIVITIES FEES	0	0	11	3	0	0		
7610	PT WAGES			39	1	0	0		
7611	PT SICK & VACATION			39	1	0	0		
7620	PT FEES	271,296	610,636	39	3	0	0	***	
7660	PT SUPPLIES	187		39	2	0	0		
7710	SOCIAL SERVICE WAGES	44,821	47,869	12	1	0	0		
7720	SOCIAL SERVICE SICK & VA	3,048		12	1	0	0		
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		
7740	OT FEE	295,831		39	3	0	0	***	
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770	SPEECH THERAPY FEE	43,509		39	3	0	0	***	
7800	BEAUTICIAN WAGES		0	40	1	0	0		
7810	BEAUTICIAN SICK & VAC			40	1	0	0		
7820	BEAUTICIAN FEES	18,082	18,082	40	3	0	0		
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910	VOLUNTEER COORDINATOR			21	1	0	0		
7940	VOL COORD SICK & VAC			21	1	0	0		
7960	VOL COORD SUPPLIES	0		21	2	0	0		
8100	RENT	328,500	328,500	34	3	0	0		
8120	INTEREST EXPENSE	34,053	34,053	32	3	14	-1,096		
8130	DEPRECIATION	0	0	30	3	9	0		
8150	LOAN FEE AMORTIZATION	0		32	3	0	0		0
9510	INTEREST INCOME	-1,096		32	0	10	0		
9520	MISC NON-OPERATING INC(	0		0	0	0	0		
9700	INCOME TAXES	7,052		0	0	0	0		
		5,293,289	5,429,819						
			136,530						
GRAND TOTALS		214,410					-190,507		
		(NET INCOME)							
		0							

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

1,009	1,009 CASH	759
1,100	1,100 ACCTS RI	1,462,660
1,101	1,101 ALLOW. I	(225,640)
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	21,047
1,220	1,220 OTHER PREPAID EXPENSES	
1,300	1,300 DIETARY INVENTORY	
1,310	1,310 SUPPLIES	0
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	11,023
1,550	1,550 LOAN FE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCO	(987,587)
2,010	2,010 ACCOUN	(195,247)
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUEI	(50,164)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUEI	(96,648)
2,120	2,120 U.C. TAX	0
2,125	2,125 FICA TAX	(4,410)
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	(21,482)
2,350	2,350 REAL ES	0
2,385		0
2,400	2,400 CURRENT PORTION OF LT DEBT	
2,512	2,512 DUE TO F	(11,023)
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	(117,698)
	net income	214,410
	balance	0

3,007	3,007 PATIENT DA	6,648
3,007	3,007 PATIENT DA	15,212
3,007	3,007 PATIENT DA	2,735
3,007		
3,007		
3,007		
3,007		
3,010	3,010 BASIC CHAR	(4,458,832)
3,020	3,020 BASIC CHAR	0
3,030	3,030 BASIC CHAR	0
3,040		135,434
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING SU	(32,910)
3,081	3,081 NURSING SU	0
3,082	3,082 NURSING SU	0
3,083	3,083 NURSING SU	0
3,100	3,100 DRUGS-MED	(933,119)
3,101		0
3,110	3,110 PHYSICAL T	(1,827,870)
3,111		0
3,112	3,112 PHYSICAL T	0
3,113	3,113 PHYSICAL T	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT THER	0
3,153	3,153 ST/OT THER	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHER I	0
3,411	3,411 MEDICARE I	0
3,420	3,420 MEDICARE I	2,019,316
3,500		
3,520	3,520 RENT INCOM	0
3,530	3,530 BEAUTY SHO	(19,129)
3,560		0
3,570	3,570	
3,590	3,590 EQUIPMENT	(1,647)
3,595	3,595 RESIDENT TI	0
3,600	3,600 MISC INCOM	(258)
4,110	4,110 G&A WAGES	142,910
4,111	4,111 ADMINISTRA	92,232
4,115	4,115 G&A PTO & I	9,853
4,120	4,120 EMPLOYEE I	7,261
4,121		
4,130	4,130 EMPLOYEE S	5,969
4,135	4,135 EMPLOYEE S	2,848
4,250	4,250 OFFICE SUPI	7,185
4,255	4,255 POSTAGE	1,325
4,260	4,260 TELEPHONE	6,997
4,275	4,275 TRAINING &	6,619
4,276		
4,280	4,280 GENERAL TI	4,396
4,281	4,281 MEAL EXPEN	0
4,285	4,285 EDUCATION	1,009
4,289	4,289 MEETINGS E	195
4,290	4,290 HELP WANTI	2,021
4,291	4,291 PROMOTION	667
4,292	4,292 PUBLIC REL/	5,548
4,300	4,300 LICENSE & F	45,977
4,310	4,310 DUES & SUB	5,682
4,320	4,320 CONTRIBUTI	0
4,350	4,350 PROFESSION	5,258
4,355	4,355 MEDICAL DI	22,680
4,362		1,880
4,363		4,482
4,364	4,364 SOCIAL SER'	5,651
4,370	4,370 TV RENTAL	6,335
4,383	4,383 BACKGROUI	1,289
4,390	4,390 OTHER TAXI	7,052
4,400	4,400 PAYROLL T/	178,217
4,401	4,401 PAYROLL T/	9,574
4,410	4,410 GROUP INSU	146,312
4,420	4,420 LIABILITY IN	37,646
4,430	4,430 WORKMAN'S	25,102
4,435	4,435 W/C-FIRST A	553
4,436	4,436 DRUG TESTI	1,444
4,450	4,450 MANAGEME	217,558
4,460	4,460 BAD DEBTS	164,335
4,461	4,461 BAD DEBTS	40,136
4,470	4,470 LOST ITEMS	0
4,475	4,475 UNIFORM E)	1,481
4,486	4,486 M.I.S. Softwar	26,199
4,490	4,490 MISC EXPEN	277
4,496	4,496 MISC. M.I.S. I	8,814
4,510	4,510 REAL ESTAT	0
4,600	4,600 LEASED EQU	1,080
5,110	5,110 MAINTENAN	60,340
5,120	5,120 MAINTENAN	6,278
5,130	5,130 ELECTRIC	72,904
5,131	5,131 NATURAL G.	5,272
5,133	5,133 WATER & SE	32,619
5,134	5,134 TRASH COLL	4,423
5,140	5,140 PROP/PLANT	4,319
5,160	5,160 GENERAL RI	41,970
5,165	5,165 MAINTENAN	20,575
5,210	5,210 DIETARY W/	165,156
5,220	5,220 DIETARY PT	9,096
5,248	5,248 FOOD PURCI	190,366
5,250	5,250 SUPPLIES DI	2,920
5,260	5,260 REPLACEME	2,989
5,270	5,270 KITCHEN SU	10,698
5,295	5,295 MEAL INCOI	(1,670)
5,310	5,310 LAUNDRY W	82,232
5,340	5,340 LAUNDRY P	15,582
5,370	5,370 REPLACEME	4,066
5,380		0
5,390	5,390 SUPPLIES	4,345
5,410	5,410 HOUSEKEEP	58,112
5,440	5,440 HOUSEKEEP	4,197
5,480	5,480 SUPPLIES-CI	22,878
5,490	5,490 SUPPLIES-H(	374
6,020	6,020 RN WAGES	257,704
6,030	6,030 DON WAGES	62,846
6,035	6,035 ADON WAGI	0
6,040	6,040 RN PTO & RI	23,346
6,120	6,120 LPN WAGES	332,574
6,140	6,140 LPN PTO & R	22,624
6,220	6,220 AIDES WAGI	612,510
6,240	6,240 AIDES PTO &	31,162
6,245		27,507
6,246		14,728
6,247		70,981
6,250		0
6,255		0
6,260		0
6,270	6,270 REHAB WAG	46,419
6,275	6,275 REHAB PTO /	2,833
6,290	6,290 NURSING SU	50,100
6,295	6,295 NURSING SU	75,210
6,390	6,390 REPLACEME	5,673
6,490	6,490 OTHER	415
7,280	7,280 DRUG PURCI	175,547
7,281	7,281 DRUG PURCI	318,336
7,380	7,380 LABORATOI	1,352
7,391	7,390 X-RAY SERV	7,837
7,393		
7,510	7,510 ACTIVITIES '	65,916
7,540	7,540 ACTIVITIES :	5,636
7,590	7,590 ACTIVITIES :	1,848
7,620	7,620 PHYSICAL T!	271,296
7,660	7,660 P.T. SUPPLY	187
7,710	7,710 SOCIAL SER'	44,821
7,720	7,720 SOCIAL SER'	3,048
7,730	7,730 SOCIAL SERVICE-EXPENSES	
7,740	7,740 OCCUPATIOI	295,831
7,750		
7,770	7,770 SPEECH THE	43,509
7,820	7,820 BEAUTICIAN	18,082
7,890		0
7,960		0
8,120	8,120 INTEREST	0
8,125		34,053
8,130	8,130 DEPRECIATI	0
8,150		0
9,510	9,510 INTEREST IN	(1,096)
9,520	9,520 MISC NON-O	0
9,530	4,220	0
	8,100	328,500
	9,702	0
	5,230	0
		214,410

Expenses Fixed Assets
0

	G/L	RECAP CENSUS
PP	6,648	6,648
IPA	15,212	15,212
medicare	2,735	2,735
		24,595

Heritage Manor Mt. Zion
HFS ID# 203903622001
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	(135,434)
		(176,609)
Provider Participation Fee	Line 42	176,609
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(493,883)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(9,189)
		(503,072)
Ancillary Service Centers	Line 39	503,072