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: 0053421

Facility Name: Heritage Health Robinson

Address: 600 E Robinwood Dr (Number) Robinson (City) 62454 (Zip Code)

County: Crawford

Telephone Number: (618) 544-3192 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 2015

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 Robinson # 0053421 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 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	73	Skilled (SNF)	67	25,026	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	73	TOTALS	67	25,026	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	11,913	3,988	2,828	18,729	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,913	3,988	2,828	18,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.84%

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 2015

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 2,828

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 Robinson # 0053421 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	152,665	9,140		161,805		161,805	3,505	165,310			1
2	Food Purchase		139,252		139,252		139,252		139,252			2
3	Housekeeping	71,479	19,293		90,772		90,772	25	90,797			3
4	Laundry	28,431	8,247		36,678		36,678		36,678			4
5	Heat and Other Utilities			62,256	62,256		62,256	1,089	63,345			5
6	Maintenance	50,936	27,915	48,896	127,747		127,747	14,664	142,411			6
7	Other (specify):*											7
8	TOTAL General Services	303,511	203,847	111,152	618,510		618,510	19,283	637,793			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,065,521	80,005	15,959	1,161,485		1,161,485	(22,424)	1,139,061			10
10a	Therapy		465,260	17,820	483,080	(482,673)	407		407			10a
11	Activities	38,933	2,163		41,096		41,096		41,096			11
12	Social Services	28,451		3,593	32,044		32,044		32,044			12
13	CNA Training							863	863			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,132,905	547,428	55,372	1,735,705	(482,673)	1,253,032	(21,561)	1,231,471			16
	C. General Administration											
17	Administrative	78,338			78,338		78,338		78,338			17
18	Directors Fees											18
19	Professional Services			186,242	186,242		186,242	(165,491)	20,751			19
20	Dues, Fees, Subscriptions & Promotions			163,980	163,980	(142,380)	21,600	(5,445)	16,155			20
21	Clerical & General Office Expenses	160,713	17,070	5,924	183,707		183,707	204,665	388,372			21
22	Employee Benefits & Payroll Taxes			356,642	356,642		356,642	27,621	384,263			22
23	Inservice Training & Education			4,913	4,913		4,913	847	5,760			23
24	Travel and Seminar			5,651	5,651		5,651	(652)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,039	32,039		32,039	11,587	43,626			26
27	Other (specify):*			49,701	49,701		49,701	(49,701)				27
28	TOTAL General Administration	239,051	17,070	805,092	1,061,213	(142,380)	918,833	23,431	942,264			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,675,467	768,345	971,616	3,415,428	(625,053)	2,790,375	21,153	2,811,528			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 Robinson #0053421 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							175,929	175,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,203	31,203		31,203	108,405	139,608			32
33	Real Estate Taxes							24,111	24,111			33
34	Rent-Facility & Grounds			319,740	319,740		319,740	(315,601)	4,139			34
35	Rent-Equipment & Vehicles			11,522	11,522		11,522	6,238	17,760			35
36	Other (specify):*											36
37	TOTAL Ownership			362,465	362,465		362,465	(918)	361,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			527,765	527,765	482,673	1,010,438	(103,654)	906,784			39
40	Barber and Beauty Shops			8,812	8,812		8,812		8,812			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					142,380	142,380		142,380			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			536,577	536,577	625,053	1,161,630	(103,654)	1,057,976			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,675,467	768,345	1,870,658	4,314,470		4,314,470	(83,419)	4,231,051			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 Robinson # 0053421 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	(66)			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	(5,024)			19
20	Contributions	(68)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,576)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,633)			24
25	Fund Raising, Advertising and Promotional	(12,134)			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)**	$ (71,501)		$	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)	(11,918)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (11,918)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (83,419)		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 Robinson

ID# 0053421

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		(68)	27	20
21				21
22		(4,576)	19	22
23				23
24		(49,633)	27	24
25		(12,134)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(66,411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Robinson # 0053421 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	3,505	0	0	0	0	0	0	0	0	3,505	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	25	0	0	0	0	0	0	0	0	25	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,089	0	0	0	0	0	0	0	0	1,089	5
6	Maintenance	0	0	14,664	0	0	0	0	0	0	0	0	14,664	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	19,283	0	0	0	0	0	0	0	0	19,283	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	(22,639)	215	0	0	0	0	0	0	0	0	(22,424)	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	863	0	0	0	0	0	0	0	0	863	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	(22,639)	1,078	0	0	0	0	0	0	0	0	(21,561)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,576)	(174,352)	13,437	0	0	0	0	0	0	0	0	(165,491)	19
20	Fees, Subscriptions & Promotions	(12,134)	0	6,689	0	0	0	0	0	0	0	0	(5,445)	20
21	Clerical & General Office Expenses	0	0	204,665	0	0	0	0	0	0	0	0	204,665	21
22	Employee Benefits & Payroll Taxes	0	0	27,621	0	0	0	0	0	0	0	0	27,621	22
23	Inservice Training & Education	0	0	847	0	0	0	0	0	0	0	0	847	23
24	Travel and Seminar	(5,024)	0	4,372	0	0	0	0	0	0	0	0	(652)	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	11,587	0	0	0	0	0	0	0	0	11,587	26
27	Other (specify):*	(49,701)	0	0	0	0	0	0	0	0	0	0	(49,701)	27
28	**TOTAL General Administration**	(71,435)	(174,352)	269,218	0	0	0	0	0	0	0	0	23,431	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,435)	(196,991)	289,579	0	0	0	0	0	0	0	0	21,153	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Robinson # 0053421 **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	156,873	0	19,056	0	0	0	0	0	0	0	175,929	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66)	108,266	0	205	0	0	0	0	0	0	0	108,405	32
33	Real Estate Taxes	0	24,111	0	0	0	0	0	0	0	0	0	24,111	33
34	Rent-Facility & Grounds	0	(319,740)	0	4,139	0	0	0	0	0	0	0	(315,601)	34
35	Rent-Equipment & Vehicles	0	0	0	6,238	0	0	0	0	0	0	0	6,238	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(66)	(30,490)	0	29,638	0	0	0	0	0	0	0	(918)	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	(103,654)	0	0	0	0	0	0	0	0	0	(103,654)	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	(103,654)	0	0	0	0	0	0	0	0	0	(103,654)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(71,501)	(331,135)	289,579	29,638	0	0	0	0	0	0	0	(83,419)	45

Facility Name & ID Number Heritage Health Robinson # 0053421 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%	$ (22,639)	$ (22,639)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(103,654)	(103,654)	3
4	V	19	Adjustment for Related Organization	174,352	Heritage Operations Group, LLC	0.00%		(174,352)	4
5	V								5
6	V	34	Adjustment for Related Organization	319,740	Heritage Manor Real Estate, LLC	0.00%		(319,740)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		24,111	24,111	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		107,378	107,378	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		156,873	156,873	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		888	888	10
11	V								11
12	V								12
13	V								13
14	Total			$ 494,092			$ 162,957	$ * (331,135)	14

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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		$	$ 3,505	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					25	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,089	19
20	V	6	Maintenance					14,664	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					215	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					863	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					13,437	31
32	V	20	Fees, Subscription, Promotions					6,689	32
33	V	21	Clerical & General Office Expenses					204,665	33
34	V	22	Employee Benefits & Payroll Taxes					27,621	34
35	V	23	Inservice Training & Education					847	35
36	V	24	Travel and Seminar					4,372	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					11,587	38
39	Total			$			$ 0	$ * 289,579	39

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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					19,056	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					205	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,139	20
21	V	35	Rent-Equipment & Vehicles					6,238	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	$ * 29,638	39

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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 Robinson # 0053421 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	67	$ 3,505	1
2	2	Food Purchase	Beds	2,571	26	0	0	67	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	67	25	3
4	4	Laundry	Beds	2,571	26	0	0	67	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	67	1,089	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	67	14,664	6
7	7	Other	Beds	2,571	26	0	0	67	0	7
8	9	Medical Director	Beds	2,571	26	0	0	67	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	67	215	9
10	11	Activities	Beds	2,571	26	0	0	67	0	10
11	12	Social Service	Beds	2,571	26	0	0	67	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	67	863	12
13	14	Program Transportation	Beds	2,571	26	0	0	67	0	13
14	15	Other	Beds	2,571	26	0	0	67	0	14
15	17	Administrative	Beds	2,571	26	0	0	67	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	67	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	67	13,437	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	67	6,689	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	67	204,665	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	67	27,621	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	67	847	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	67	4,372	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	67	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	67	11,587	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 289,579	25

Facility Name & ID Number Heritage Health Robinson # 0053421 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	$	$	67	$	1
2	30	Depreciation	Beds	2,571	26	731,247		67	19,056	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			67		3
4	32	Interest	Beds	2,571	26	7,851		67	205	4
5	33	Real Estate Taxes	Beds	2,571	26			67		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		67	4,139	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		67	6,238	7
8	36	Other	Beds	2,571	26			67		8
9	38	Medically Nec Transportation	Beds	2,571	26			67		9
10	39	Ancillary Service Centers	Beds	2,571	26			67		10
11	40	Barber and Beauty Shops	Beds	2,571	26			67		11
12	41	Coffee and Gift Shops	Beds	2,571	26			67		12
13	42	Other	Beds	2,571	26			67		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	$		$ 29,638	25

Facility Name & ID Number Heritage Health Robinson # 0053421 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	Morton Community Bank		x	Mortgage			$	$			$ 107,378	1
2	Morton Community Bank		x	Loan Fee Amortization							888	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x								31,203	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 139,469	9
	B. Non-Facility Related*											
10	Interest Income										(66)	10
11												11
12	Allocated Corporate										205	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 139	14
15	TOTALS (line 9+line14)						$	$			$ 139,608	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 Robinson # 0053421 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.)		$ 24,111	2
3. Under or (over) accrual (line 2 minus line 1).		$ 24,111	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.		$ 24,111	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	22,614	8
	2012	22,138	9
	2013	22,428	10
	2014	22,431	11
	2015	24,111	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 Robinson COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0053421

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.	05427033042		$ 23,766.30	$ 23,766.00
2.	05427033041		$ 344.40	$ 345.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,110.70	$ 24,111.00

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 Robinson # 0053421 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,869 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				$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number Heritage Health Robinson # 0053421 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	67				$ 1,525,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Acquisition of Building Improvements from prior Operator			2001	154,177						9
10											10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291						11
12	Dinning Room/Day Room Addition---Design			2001	50,288						12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670						13
14											14
15	Dinning Room/Day Room Addition---Outside Contractor			2002	66,633						15
16	Dinning Room/Day Room Addition---Design			2002	4,665						16
17	Heating Duct Replacement			2002	12,146						17
18											18
19	Dinning Room/Day Room Addition---Paid by ProCare			2002	200,750						19
20	directly to General Contractor										20
21											21
22	Heat Pump			2003	12,720						22
23	Compressor			2003	1,333						23
24	A/C Unit			2003	2,569						24
25	Water Heater			2003	7,262						25
26	Sprinkler Head Replacements			2003	3,993						26
27	Asphalt Sealing			2003	1,260						27
28	idph			2003	8,618						28
29											29
30	Rewire Resident Rooms			2004	3,250						30
31											31
32											32
33	C/O Allocation					19,056		19,056			33
34	Book Depreciation					118,154		118,154			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 Robinson # 0053421 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	Parking Lot Sealer	2005	$ 1,260	$		$	$	$	37
38	Doors	2005	660						38
39	A/C compressor	2005	983						39
40	Sidewalk	2005	7,898						40
41	Ansul System	2005	1,990						41
42									42
43	Furnace	2006	4,850						43
44	Roof	2006	7,230						44
45	A/C compressor	2006	1,354						45
46	Water line	2006	1,119						46
47									47
48	A/C	2007	6,406						48
49	Parking Lot	2007	36,176						49
50									50
51	CC TV system	2008	3,397						51
52	Parking Lot	2008	15,919						52
53	Hallway Painting	2008	5,325						53
54	Landscaping	2008	9,896						54
55	Exit Doors	2008	4,138						55
56									56
57									57
58	Furnace	2009	7,443						58
59	Dumpster Pad	2009	3,400						59
60	Parking Lot	2009	2,619						60
61	Door Closers	2009	4,465						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,355,153	$ 137,210		$ 137,210	$	$	70

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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		$ 2,355,153	$ 137,210		$ 137,210	$	$	1
2									2
3	General Conditions & Demolition	2009	73,230						3
4	Carpentry & Millwork	2009	45,270						4
5	Acoustical Ceiling & Flooring	2009	49,176						5
6	Painting	2009	36,800						6
7	Plumbing	2009	10,600						7
8	Electrical	2009	18,430						8
9	Design and layout	2009	13,837						9
10	Project Materials	2009	99,339						10
11	Interior Doors and toilets & related hardware	2009	67,621						11
12	Flooring Central Core	2009	23,320						12
13									13
14	Service sink	2010	5,225						14
15	AHU replacement	2010	4,934						15
16									16
17	Window treatments & tile	2011	4,481						17
18	Walk-in cooler	2011	38,164						18
19									19
20	Water Heater	2012	14,802						20
21									21
22	Replacement Chassis - 2 SC Units	2013	2,841						22
23	New Exterior Sign	2013	7,014						23
24	Condensing Unit - Kitchen	2013	3,030						24
25	HVAC Unit - Laundry	2013	3,575						25
26	Window Replacement and Corridor Flooring/Painting	2013	127,782						26
27									27
28	Cabling and Electric - Wireless Network	2014	10,819						28
29	Install Exterior Door	2014	2,551						29
30	Ductless Split System Installation	2014	7,329						30
31	Install New Fire Alarm System	2014	5,250						31
32	Roof Replacement	2014	35,090						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,065,663	$ 137,210		$ 137,210	$	$	34

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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		$ 3,065,663	$ 137,210		$ 137,210	$	$	1
2									2
3	Install 5 ton AC condenser	2015	6,200						3
4									4
5	No 2016 improvements								5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,071,863	$ 137,210		$ 137,210	$	$	34

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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	$ 860,365	$ 38,719	$ 38,719	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 860,365	$ 38,719	$ 38,719	$		$	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)	$ 3,958,228	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 175,929	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 175,929	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 Robinson # 0053421 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: $ 11,522 Description: Televisions and office machines
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	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 Robinson # 0053421 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 233,648	$		$ 233,648	1
2	Licensed Speech and Language Development Therapist		hrs			53,470			53,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			240,647	407		241,054	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				464,853		464,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,820			17,820	13
14	TOTAL			$		$ 545,585	$ 465,260		$ 1,010,845	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Robinson **#** 0053421 **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	$ 27,602	$	1
2	Cash-Patient Deposits	6,505		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,160,943		3
4	Supply Inventory (priced at FIFO)	18,809		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,861		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,138,211)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 95,509	$	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)**	$ 95,509	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 149,022	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,505		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,838		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,614		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	16,122		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 327,101	$	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)**	$ 327,101	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (231,592)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 95,509	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Robinson # 0053421 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**	$ 862,049	1
2	Restatements (describe):		2
3	**Reclass expired joint venture investment**	(889,085)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (27,036)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,556)	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)**	$ (204,556)	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)**	$ (231,592)	24 *

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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	$ 3,544,912	1
2	Discounts and Allowances for all Levels	(2,141,483)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,403,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,833,095	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,833,095	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	7,770	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	862,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,844	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 873,324	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,109,914	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	618,510	31
32	Health Care	1,735,705	32
33	General Administration	1,061,213	33
	B. Capital Expense		
34	Ownership	362,465	34
	C. Ancillary Expense		
35	Special Cost Centers	536,577	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,314,470	40
41	**Income before Income Taxes (line 30 minus line 40)****	(204,556)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (204,556)	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 Robinson # 0053421 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	1,540	1,621	$ 54,247	$ 33.47	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	11,176	11,764	316,392	26.89	3
4	Licensed Practical Nurses	5,401	5,685	115,126	20.25	4
5	CNAs & Orderlies	40,371	42,496	519,384	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,763	2,908	60,372	20.76	8
9	Activity Director					9
10	Activity Assistants	3,169	3,336	38,933	11.67	10
11	Social Service Workers	1,930	2,032	28,451	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,133	15,930	152,665	9.58	15
16	Dishwashers					16
17	Maintenance Workers	3,073	3,235	50,936	15.75	17
18	Housekeepers	6,935	7,300	71,479	9.79	18
19	Laundry	3,058	3,219	28,431	8.83	19
20	Administrator	1,984	2,088	78,338	37.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,790	7,147	160,713	22.49	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)	103,323	108,761	$ 1,675,467 *	$ 15.41	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		18,000		36
37	Medical Records Consultant		359		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,547		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,593		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,499		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		11,946		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		$ 11,946		53

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roxann Summers			$ 78,338
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,338

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	$ 174,352
ADP	Payroll tax processing	1,233
Tango Inc	ACA compliance	476
Legal adj to Zero		10,181
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 186,242

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,586
Unemployment Compensation Insurance	36,592
FICA Taxes	128,173
Employee Health Insurance	99,268
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	27,023
Central Office Allocation	27,621
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,263

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,286
Health Care Worker Background Check	
(Indicate # of checks performed)	1,965
PR	3,131
Dues & Subscriptions	4,050
License & Fees	2,178
Central Office Allocation	6,689
Less: Public Relations Expense	(3,131)
Non-allowable advertising	(2,013)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,155

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	5,406
	0
Seminar Expense	245
	(652)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Robinson # 0053421 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 political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

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

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **142,380**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,785**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sulaski & Webb**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees

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	27,602							
1010		CASH IN BANK								
1040		CASH IN BANK-PAYROLL								
1100		ACCOUNTS RECEIVABLE	1,160,943							
1110		MEDICARE RECEIVABLES								
1125		IPA INCOME RECEIVABLE								
1130		MEDICARE COST REPORT								
1135		ACCOUNTS RECEIVABLE-IC								
1140		UNAPPLIED CASH RECEIPTS								
1145		A/R SUSPENSE-REFUNDS								
1190		ACCRUED INTEREST REC								
1200		PREPAID INSURANCE	19,861							
1220		OTHER PREPAID EXPENSES								
1300		FOOD INVENTORY								
1310		SUPPLIES INVENTORY	18,809							
1409		LAND	0							
1450		FURNITURE & EQUIPMENT	0							
1460		ACCUM DEPR-FURN & EQUI	0							
1475		BUILDING & IMPROVEMEN	0							
1490		ACCUM DEPR-BUILDING	0							
1530		RESIDENT FUNDS	6,505							
1550		LOAN FEES	0							
1560		REAL ESTATE TAX ESCROW								
1575		REIMBURSABLE PURCHASES								
1850		INTRACOMPANY	-1,138,211							
2010		ACCOUNTS PAYABLE	-149,022							
2095		BONUSES PAYABLE								
2100		ACCRUED PAYROLL	-71,470							
2110		ACCRUED VACATION PAY	-79,368							
2120		UC TAXES PAYABLE								
2125		FICA TAX PAYABLE	-4,614	-4,614						
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	-16,122							
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	-6,505							
2600		MORTGAGE PAYABLE	0							
2650		EQUIPMENT LOAN PAYABLE								
2695		CURRENT PORTION LT DEBT								
2696		DEFERRED INCOME TAXES								
2710		COMMON STOCK								
2720		RETAINED EARNINGS	27,036							
2970		PROFIT/LOSS FOR PERIOD	204,556							
3007.1		PATIENT DAYS-PRIVATE	3,988							
3007.2		PATIENT DAYS-IPA	11,913							
3007.3		PATIENT DAYS-MEDICARE	2,828							
3007.4		PATIENT DAYS-CONVERSION								
3007.5		PATIENT DAYS-LICENSED								
3007.6		PATIENT DAYS-TOTAL								
3010	1	BASIC CHARGE-PRIVATE &	-3,528,544		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	-10,745		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	-862,710		0	0	0	0		
3101	17	DRUGS-OTHER								
3110	6	PT-PRIVATE	-1,833,095		0	0	0	0		
3111	6	PT-IPA			0	0	0	0		
3112	6	PT-MEDICARE PART A			0	0	0	0		
3113	6	PT-MEDICARE PART B			0	0	0	0		
3130	1	PUBLIC AID ASSESSMENT II	104,841							
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	2,141,483		0	0	0	0		
3411	2	MEDICAID PART B DISCOUNT			0	0	0	0		
3420	2	MEDICARE DISCOUNTS			0	0	0	0		
3440	36	ASSESSMENT TAX EXPENSE			42	3	0	0		
3520	16	RENT INCOME	0		6	0	6	0		
3530	13	BEAUTY SHOP	-7,770		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	-5,623		0	0	0	0		
3595	21	RESIDENT TRANSPORTATIC	-2,844		0	0	0	0		
3600	21	MISC INCOME	0		0	0	0	0		
4110		GENERAL & ADMINIST WA(	147,097	160,713	21	1	17	0		
4111		ADMINISTRATOR WAGES	78,338	78,338	17	1	0	0		
4115		VACATION & SICK - G&A	13,616		21	1	0	0		
4120	4475	EMPLOYEE BENEFITS	10,594	356,642	22	3	0	0		
4125		EMPLOYEE HEPETITIS VAC(	0		22	3	0	0		
4130		EMPLOYEE SCHOLORSHIP \	0	104,841	21	1	0	0		
4135		EMPLOYEE SCHOLORSHIP (	16,429		23	3	0	0		
4220		DIRECTORS FEES	0	0	18	3	0	0		
4250	4255	OFFICE SUPPLIES	17,070	17,070	21	2	0	0		
4260		TELEPHONE	5,924	5,924	21	3	0	0		
4275		TRAINING & EMPLOYEE DE	4,913	4,913	23	3	16	0	**	
4280		GENERAL TRAVEL	5,406	5,651	24	3	16	0		
4281		MEAL EXPENSE FOR TRAVE	0		24	3	19	0		
4285		EDUCATION & SEMINAR	245		24	3	19	-5,024	***	
4290		HELP WANTED ADVERTISIN	3,286	59,139	20	3	0	0		-37,539
4291		PROMOTIONAL ADVERTISII	6,990		20	3	25	-6,990		
4292		PUBLIC RELATIONS	3,131		20	3	25	-3,131		
4300		LICENSES & FEES	39,717		20	3	17	0		
4310		DUES & SUBSCRIPTIONS	4,050		20	3	17	-2,013		
4320		CONTRIBUTIONS	68		27	3	20	-68		
4350		PROFESSIONAL FEES	11,890	186,242	19	3	22	-4,576		
4355		MEDICAL DIRECTOR	18,000	18,000	9	3	0	0		
4360		UTILIZATION REVIEW	0		10	3	0	0		
4361		OTHER PHYSICIAN FEES			39	3	0	0		
4362		MEDICAL RECORDS CONSU	359		10	3	0	0		
4363		PHARMACIST FEES	3,547		10	3	0	0		
4364		SOC SERV/ACT CONSULT	3,593	3,593	12	3	0	0		
4370		TV RENTAL	1,179		35	3	5	0		
4380		INCOME TAXES		49,701	27	3	26	0		
4383		BACKGROUND CHECKS	1,965		20	3	26	0		
4400		PAYROLL TAXES	156,634		22	3	0	0		
4401		PAYROLL TAXES ADMINIST	8,131		22	3	0	0		
4410		GROUP INSURANCE	99,268		22	3	0	0		
4420		LIABILITY INSURANCE	32,039	32,039	26	3	0	0		
4425		INSURANCE-OWNERS			22	3	21	0		
4430		WORKMENS COMP INSURAI	65,586		22	3	0	0		
4450		CENTRAL OFFICE FEES	174,352		19	3	34	0	**	
4460		BAD DEBTS	49,633		27	3	24	-49,633		
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	10,343	11,522	35	3	16	0		
5110		MAINTENANCE SALARIES	47,605	50,936	6	1	0	0		
5120		MAINTENANCE SICK & VAC	3,331		6	1	0	0		
5130		ELECTRIC	41,557	62,256	5	3	0	0		
5131		NATURAL GAS	5,803		5	3	0	0		
5132		HEATING & DEISEL OIL			5	3	0	0		
5133		WATER & SEWER	14,896		5	3	0	0		
5134		TRASH COLLECTION	14,881	48,896	6	3	0	0		
5140		PROPERTY PLANT REPLACE	3,105	27,915	6	2	0	0		
5160		GENERAL REPAIR & MAINT	24,810		6	2	0	0		
5165		MAINTENANCE CONTRACT	34,015		6	3	0	0		
5210		DIETARY WAGES	147,014	152,665	1	1	0	0		
5220		DIETARY SICK & VAC	5,651		1	1	0	0		
5240		SALES TAX			2	3	13	0		
5248		FOOD PURCHASES	141,037	139,252	2	2	0	0		
5250		SUPPLIES-DISHWASHING	1,035	9,140	1	2	0	0		
5260		DIETARY REPLACEMENT	902		1	2	0	0		
5270		KITCHEN SUPPLIES-PAPER	7,203		1	2	0	0		
5295		MEAL CREDIT	-1,785		2	2	0	0		
5310		LAUNDRY WAGES	27,311	28,431	4	1	0	0		
5340		LAUNDRY SICK & VAC	1,120		4	1	0	0		
5370		LAUNDRY REPLACEMENT	4,558	8,247	4	2	0	0		
5380		LAUNDRY REIMBURSEMENT			4	3	0	0		
5390		LAUNDRY SUPPLIES	3,689		4	2	0	0		
5410		HOUSEKEEPING WAGES	67,568	71,479	3	1	0	0		
5440		HOUSEKEEPING SICK & VA(	3,911		3	1	0	0		
5480		HOUSEKEEPING SUPPLIES	19,293	19,293	3	2	0	0		
5490		HOUSEKEEPING SUPPLIES-F	0		3	2	0	0		
6010		RN WAGES-MEDICARE		1,065,521	10	1	0	0		
6020		RN WAGES-NON MEDICARE	288,086		10	1	0	0		
6030		DON WAGES	54,247		10	1	0	0		
6035		ADON	0		10	1	0	0		
6040		RN SICK & VACATION	28,306		10	1	0	0		
6110		LPN WAGES-MEDICARE	110,958		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	4,168		10	1	0	0		
6210		AIDE WAGES-MEDICARE			10	1	0	0		
6220		AIDE WAGES-NON MEDICAI	491,499		10	1	0	0		
6230		WARD CLERKS			10	1	0	0		
6240		AIDE VACATION & SICK	27,885		10	1	0	0		
6245		CONTRACT NURSES-RN	0		10	3	0	0		
6246		CONTRACT NURSES-LPN	11,946		10	3	0	0		
6247		CONTRACT NURSES-AIDES	0		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 REII	0		0	0	0	0		
6270		REHAB WAGES	55,072		10	1	0	0		
6275		REHAB SICK & VAC	5,300		10	1	0	0		
6280		NURSING DEPT EDUCATION			23	3	0	0		
6290		NURSING SUPPLIES	60,344	80,005	10	2	0	0		
6295		NURSING SUPPLIES	14,613		10	2	0	0		
6390		REPLACEMENT-NURSING	5,048		10	2	0	0		
6490		NURSING OTHER	107	15,959	10	3	0	0		
7280		DRUG PURCHASES	197,500	465,260	39	2	0	0	***	
7281		DRUG PURCHASES-OTHER	267,353		39	2				
7380		LABORATORY SERVICES	17,820	17,820	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	36,511	38,933	11	1	0	0		
7540		ACTIVITIES SICK & VAC	2,422		11	1	0	0		
7590		ACTIVITIES SUPPLIES	2,163	2,163	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	240,647	527,765	39	3	0	0	***	
7660		PT SUPPLIES	407		39	2	0	0		
7710		SOCIAL SERVICE WAGES	27,141	28,451	12	1	0	0		
7720		SOCIAL SERVICE SICK & VA	1,310		12	1	0	0		
7730		SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		
7740		OT FEE	233,648		39	3	0	0	***	
7750		SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770		SPEECH THERAPY FEE	53,470		39	3	0	0	***	
7800		BEAUTICIAN WAGES		0	40	1	0	0		
7810		BEAUTICIAN SICK & VAC			40	1	0	0		
7820		BEAUTICIAN FEES	8,812	8,812	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	319,740	319,740	34	3	0	0		
8120		INTEREST EXPENSE	31,203	31,203	32	3	14	-66		
8130		DEPRECIATION	0	0	30	3	9	0		
8150		LOAN FEE AMORTIZATION	0		32	3	0	0		0
9510		INTEREST INCOME	-66		32	0	10	0		
9520		MISC NON-OPERATING INC(	0		0	0	0	0		
9700		INCOME TAXES	0		0	0	0	0		
			4,209,563	4,314,470						
				104,907						
GRAND TOTALS			204,556					-71,501		
			(NET INCOME)							
			0							

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

1,009	1,009	CASH	27,602
1,100	1,100	ACCTS RI	1,320,504
1,101	1,101	ALLOW. I	(159,561)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID	19,861
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVENTORY	
1,310	1,310	SUPPLIES	18,809
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	6,505
1,550	1,550	LOAN FE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	(1,138,211)
2,010	2,010	ACCOUN	(149,022)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEI	(71,470)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEI	(79,368)
2,120	2,120	U.C. TAX	0
2,125	2,125	FICA TAX	(4,614)
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 G/	0
2,300	2,300	ACCRUEI	0
2,320	2,320	IPA PAYM	(16,122)
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	(6,505)
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	27,036
		net income	204,556
		balance	0

3,007	3,007	PATIENT DA	3,988
3,007	3,007	PATIENT DA	11,913
3,007	3,007	PATIENT DA	2,828
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHAR	(3,528,544)
3,020	3,020	BASIC CHAR	0
3,030	3,030	BASIC CHAR	0
3,040			104,841
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SU	(10,745)
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	(862,710)
3,101			0
3,110	3,110	PHYSICAL TI	(1,833,095)
3,111			0
3,112	3,112	PHYSICAL TI	0
3,113	3,113	PHYSICAL TI	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 F	0
3,420	3,420	MEDICARE I	2,044,086
3,500			
3,520	3,520	RENT INCOM	0
3,530	3,530	BEAUTY SH(	(7,770)
3,560			0
3,570	3,570		
3,590	3,590	EQUIPMENT	(5,623)
3,595	3,595	RESIDENT TI	(2,844)
3,600	3,600	MISC INCOM	0
4,110	4,110	G&A WAGES	147,097
4,111	4,111	ADMINISTRA	78,338
4,115	4,115	G&A PTO & I	13,616
4,120	4,120	EMPLOYEE I	9,926
4,121			
4,130	4,130	EMPLOYEE S	0
4,135	4,135	EMPLOYEE S	16,429
4,250	4,250	OFFICE SUPI	3,924
4,255	4,255	POSTAGE	1,102
4,260	4,260	TELEPHONE	5,924
4,275	4,275	TRAINING &	4,913
4,276			
4,280	4,280	GENERAL TF	5,406
4,281	4,281	MEAL EXPEI	0
4,285	4,285	EDUCATION	245
4,289	4,289	MEETINGS E	0
4,290	4,290	HELP WANTI	3,286
4,291	4,291	PROMOTION	6,990
4,292	4,292	PUBLIC REL/	3,131
4,300	4,300	LICENSE & F	39,717
4,310	4,310	DUES & SUB	4,050
4,320	4,320	CONTRIBUTI	68
4,350	4,350	PROFESSION	11,890
4,355	4,355	MEDICAL DI	18,000
4,362			359
4,363			3,547
4,364	4,364	SOCIAL SER'	3,593
4,370	4,370	TV RENTAL	1,179
4,383	4,383	BACKGROUI	1,965
4,390	4,390	OTHER TAXI	0
4,400	4,400	PAYROLL T/	156,634
4,401	4,401	PAYROLL T/	8,131
4,410	4,410	GROUP INSU	99,268
4,420	4,420	LIABILITY II	32,039
4,430	4,430	WORKMAN'S	62,353
4,435	4,435	W/C-FIRST A	526
4,436	4,436	DRUG TESTI	2,707
4,450	4,450	MANAGEME	174,352
4,460	4,460	BAD DEBTS	49,633
4,461	4,461	BAD DEBTS	97,397
4,470	4,470	LOST ITEMS-	0
4,475	4,475	UNIFORM EX	668
4,486	4,486	M.I.S. Softwar	18,281
4,490	4,490	MISC EXPEN	411
4,496	4,496	MISC. M.I.S. I	12,044
4,510	4,510	REAL ESTAT	0
4,600	4,600	LEASED EQU	10,343
5,110	5,110	MAINTENAN	47,605
5,120	5,120	MAINTENAN	3,331
5,130	5,130	ELECTRIC	41,557
5,131	5,131	NATURAL G.	5,803
5,133	5,133	WATER & SE	14,896
5,134	5,134	TRASH COLI	14,881
5,140	5,140	PROP/PLANT	3,105
5,160	5,160	GENERAL RI	24,810
5,165	5,165	MAINTENAN	15,734
5,210	5,210	DIETARY W/	147,014
5,220	5,220	DIETARY PT	5,651
5,248	5,248	FOOD PURCI	140,626
5,250	5,250	SUPPLIES DI	1,035
5,260	5,260	REPLACEME	902
5,270	5,270	KITCHEN SU	7,203
5,295	5,295	MEAL INCOI	(1,785)
5,310	5,310	LAUNDRY W	27,311
5,340	5,340	LAUNDRY P	1,120
5,370	5,370	REPLACEME	4,558
5,380			0
5,390	5,390	SUPPLIES	3,689
5,410	5,410	HOUSEKEEP	67,568
5,440	5,440	HOUSEKEEP	3,911
5,480	5,480	SUPPLIES-CI	19,293
5,490	5,490	SUPPLIES-H(	0
6,020	6,020	RN WAGES	288,086
6,030	6,030	DON WAGES	54,247
6,035	6,035	ADON WAGE	0
6,040	6,040	RN PTO & RE	28,306
6,120	6,120	LPN WAGES	110,958
6,140	6,140	LPN PTO & R	4,168
6,220	6,220	AIDES WAGI	491,499
6,240	6,240	AIDES PTO &	27,885
6,245			0
6,246			11,946
6,247			
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB WAG	55,072
6,275	6,275	REHAB PTO	5,300
6,290	6,290	NURSING SU	60,344
6,295	6,295	NURSING SU	14,613
6,390	6,390	REPLACEME	5,048
6,490	6,490	OTHER	107
7,280	7,280	DRUG PURCI	197,500
7,281	7,281	DRUG PURCI	267,353
7,380	7,380	LABORATOI	11,399
7,391	7,390	X-RAY SERV	6,421
7,393			
7,510	7,510	ACTIVITIES	36,511
7,540	7,540	ACTIVITIES I	2,422
7,590	7,590	ACTIVITIES	2,163
7,620	7,620	PHYSICAL TI	240,647
7,660	7,660	P.T. SUPPLY	407
7,710	7,710	SOCIAL SER'	27,141
7,720	7,720	SOCIAL SER'	1,310
7,730	7,730	SOCIAL SERVICE-EXPENSES	
7,740	7,740	OCCUPATIOI	233,648
7,750			0
7,770	7,770	SPEECH THE	53,470
7,820	7,820	BEAUTICIAN	8,812
7,890			0
7,960			0
8,120	8,120	INTEREST	0
8,125			31,203
8,130	8,130	DEPRECIATI	0
8,150			0
9,510	9,510	INTEREST IN	(66)
9,520	9,520	MISC NON-O	0
9,530	4,220		0
	8,100		319,740
	9,702		0
	5,230		0
			204,556

Expenses Fixed Assets 0

	G/L	RECAP CENSUS
PP	3,988	3,988
IPA	11,913	11,913
medicare	2,828	2,828
		18,729

Heritage Manor Robinson
HFS ID# 472140069001
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	(37,539)
Provider Assesment Fee - $6.07	Line 20, Col 3	(104,841)
		(142,380)
Provider Participation Fee	Line 42	142,380
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(464,853)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(17,820)
		(482,673)
Ancillary Service Centers	Line 39	482,673