

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

<p>I. IDPH License ID Number: <u>48058</u></p> <p>Facility Name: <u>Heritage Manor Minonk LLC</u></p> <p>Address: <u>201 Locust</u> <u>Minonk</u> <u>61760</u> Number City Zip Code</p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 432-2557</u> Fax # <u>()</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2006</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David M Underwood</u> Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>David M Underwood</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>EVP/CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>David M Underwood</u>		(Title) <u>EVP/CFO</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____																
Officer or Administrator of Provider	(Signed) _____ (Date) _____																	
	(Type or Print Name) <u>David M Underwood</u>																	
	(Title) <u>EVP/CFO</u>																	
Paid Preparer	(Signed) _____ (Date) _____																	
	(Print Name and Title) _____																	
	(Firm Name & Address) _____																	
	(Telephone) <u>()</u> Fax # <u>()</u>																	

Facility Name & ID Number Heritage Manor Minonk LLC

48058 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,395	5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,771	5,734	1,215	10,720	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,964		1,964	12
13	DD 16 OR LESS					13
14	TOTALS	3,771	7,698	1,215	12,684	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.26%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 7/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 49 and days of care provided 1,215

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	165,943	11,327	4,623	181,893		181,893	2,906	184,799		1
2	Food Purchase		105,532		105,532		105,532	38	105,570		2
3	Housekeeping	43,650	14,536		58,186		58,186		58,186		3
4	Laundry	35,667	4,164		39,831		39,831	3	39,834		4
5	Heat and Other Utilities			64,888	64,888		64,888	1,055	65,943		5
6	Maintenance	63,360	32,134	53,104	148,598		148,598	15,949	164,547		6
7	Other (specify):*										7
8	TOTAL General Services	308,620	167,693	122,615	598,928		598,928	19,951	618,879		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	795,350	44,995	59,820	900,165		900,165	(8,964)	891,201		10
10a	Therapy		88,493	16,983	105,476	(104,424)	1,052		1,052		10a
11	Activities	56,359	6,223		62,582		62,582		62,582		11
12	Social Services	46,365		1,804	48,169		48,169		48,169		12
13	CNA Training							835	835		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	898,074	139,711	78,607	1,116,392	(104,424)	1,011,968	(8,129)	1,003,839		16
	C. General Administration										
17	Administrative	77,667			77,667		77,667		77,667		17
18	Directors Fees										18
19	Professional Services			150,555	150,555		150,555	(137,135)	13,420		19
20	Dues, Fees, Subscriptions & Promotions			117,503	117,503	(85,707)	31,796	(10,715)	21,081		20
21	Clerical & General Office Expenses	147,766	47,236	8,874	203,876		203,876	255,286	459,162		21
22	Employee Benefits & Payroll Taxes			262,458	262,458		262,458	33,298	295,756		22
23	Inservice Training & Education			2,310	2,310		2,310	1,251	3,561		23
24	Travel and Seminar			6,671	6,671		6,671	(1,672)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			26,479	26,479		26,479	17,957	44,436		26
27	Other (specify):*			9,262	9,262		9,262	(9,243)	19		27
28	TOTAL General Administration	225,433	47,236	584,112	856,781	(85,707)	771,074	149,027	920,101		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,432,127	354,640	785,334	2,572,101	(190,131)	2,381,970	160,849	2,542,819		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							203,001	203,001			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,505	28,505		28,505	35,169	63,674			32
33	Real Estate Taxes							32,082	32,082			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(310,944)	4,416			34
35	Rent-Equipment & Vehicles			28,168	28,168		28,168	4,472	32,640			35
36	Other (specify):*											36
37	TOTAL Ownership			372,033	372,033		372,033	(36,220)	335,813			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			331,567	331,567	104,424	435,991	98,172	534,163			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					85,707	85,707		85,707			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			331,567	331,567	190,131	521,698	98,172	619,870			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,432,127	354,640	1,488,934	3,275,701		3,275,701	222,801	3,498,502			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 Manor Minonk LLC

48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(292)			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	(7,028)			19
20	Contributions	(50)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,666)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,193)			24
25	Fund Raising, Advertising and Promotional	(17,668)			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)	\$ (35,897)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	258,698		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 258,698		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 222,801		37

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

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

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

Heritage Manor Minonk LLC

ID# 48058

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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				15
16				16
17				17
18				18
19				19
20				20
21				21
22		0	30	22
23		(1,666)	19	23
24		(9,193)	27	24
25		(17,668)	20	25
26		(7,028)	24	26
27		(50)	27	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,605)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Minonk LLC# 48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	2,906	0	0	0	0	0	0	0	0	2,906	1
2	Food Purchase	0	0	38	0	0	0	0	0	0	0	0	38	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	3	0	0	0	0	0	0	0	0	3	4
5	Heat and Other Utilities	0	0	1,055	0	0	0	0	0	0	0	0	1,055	5
6	Maintenance	0	0	15,949	0	0	0	0	0	0	0	0	15,949	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	19,951	0	0	0	0	0	0	0	0	19,951	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(9,429)	465	0	0	0	0	0	0	0	0	(8,964)	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	835	0	0	0	0	0	0	0	0	835	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(9,429)	1,300	0	0	0	0	0	0	0	0	(8,129)	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	(1,666)	(147,789)	12,320	0	0	0	0	0	0	0	0	(137,135)	19
20	Fees, Subscriptions & Promotions	(17,668)	0	6,953	0	0	0	0	0	0	0	0	(10,715)	20
21	Clerical & General Office Expenses	0	0	255,286	0	0	0	0	0	0	0	0	255,286	21
22	Employee Benefits & Payroll Taxes	0	0	33,298	0	0	0	0	0	0	0	0	33,298	22
23	Inservice Training & Education	0	0	1,251	0	0	0	0	0	0	0	0	1,251	23
24	Travel and Seminar	(7,028)	0	5,356	0	0	0	0	0	0	0	0	(1,672)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	17,957	0	0	0	0	0	0	0	0	17,957	26
27	Other (specify):*	(9,243)	0	0	0	0	0	0	0	0	0	0	(9,243)	27
28	TOTAL General Administration	(35,605)	(147,789)	332,421	0	0	0	0	0	0	0	0	149,027	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(35,605)	(157,218)	353,672	0	0	0	0	0	0	0	0	160,849	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Minonk LLC

48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	182,679	0	20,322	0	0	0	0	0	0	0	203,001	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(292)	35,461	0	0	0	0	0	0	0	0	0	35,169	32
33	Real Estate Taxes	0	32,082	0	0	0	0	0	0	0	0	0	32,082	33
34	Rent-Facility & Grounds	0	(315,360)	0	4,416	0	0	0	0	0	0	0	(310,944)	34
35	Rent-Equipment & Vehicles	0	0	0	4,472	0	0	0	0	0	0	0	4,472	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(292)	(65,138)	0	29,210	0	0	0	0	0	0	0	(36,220)	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	98,172	0	0	0	0	0	0	0	0	0	98,172	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	98,172	0	0	0	0	0	0	0	0	0	98,172	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(35,897)	(124,184)	353,672	29,210	0	0	0	0	0	0	0	222,801	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	10 Adjustment for Related Organization	\$	GreenTree Pharmacy		\$ (9,429)	\$	(9,429) 1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy				2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		98,172		98,172 3
4	V	19 Adjustment for Related Organization	147,789	Heritage Operations Group, LLC				(147,789) 4
5	V							5
6	V	34 Adjustment for Related Organization	315,360	Heritage Manor Real Estate, LLC				(315,360) 6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		32,082		32,082 7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		25,743		25,743 8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		182,679		182,679 9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		9,718		9,718 10
11	V							11
12	V							12
13	V							13
14	Total		\$ 463,149			\$ 338,965	\$ *	(124,184) 14

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

Facility Name & ID Number

Heritage Manor Minonk LLC

48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Operations Group		\$	2,906	15
16	V	2 Food Purchase		Heritage Operations Group			38	16
17	V	3 Housekeeping		Heritage Operations Group			0	17
18	V	4 Laundry		Heritage Operations Group			3	18
19	V	5 Heat & Other Utilities		Heritage Operations Group			1,055	19
20	V	6 Maintenance		Heritage Operations Group			15,949	20
21	V	7 Other		Heritage Operations Group			0	21
22	V	9 Medical Director		Heritage Operations Group			0	22
23	V	10 Nursing & Medical Records		Heritage Operations Group			465	23
24	V	11 Activities		Heritage Operations Group			0	24
25	V	12 Social Service		Heritage Operations Group			0	25
26	V	13 Nurse Aide Training		Heritage Operations Group			835	26
27	V	14 Program Transportation		Heritage Operations Group			0	27
28	V	15 Other		Heritage Operations Group			0	28
29	V	17 Administrative		Heritage Operations Group			0	29
30	V	18 Directors Fees		Heritage Operations Group			0	30
31	V	19 Professional Services		Heritage Operations Group			12,320	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			6,953	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			255,286	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			33,298	34
35	V	23 Inservice Training & Education		Heritage Operations Group			1,251	35
36	V	24 Travel and Seminar		Heritage Operations Group			5,356	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			17,957	38
39	Total		\$			\$	0	\$ * 353,672 39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Operations Group		\$	0	15
16	V	30 Depreciation		Heritage Operations Group			20,322	16
17	V	31 Amortization of Pre-Op & Org		Heritage Operations Group			0	17
18	V	32 Interest		Heritage Operations Group			0	18
19	V	33 Real Estate Taxes		Heritage Operations Group			0	19
20	V	34 Rent-Facility & Grounds		Heritage Operations Group			4,416	20
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			4,472	21
22	V	36 Other		Heritage Operations Group			0	22
23	V	38 Medically Nec Transportation		Heritage Operations Group			0	23
24	V	39 Ancillary Service Centers		Heritage Operations Group			0	24
25	V	40 Barber and Beauty Shops		Heritage Operations Group			0	25
26	V	41 Coffee and Gift Shops		Heritage Operations Group			0	26
27	V	42 Other		Heritage Operations Group			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	\$ * 29,210 39

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

Facility Name & ID Number

Heritage Manor Minonk LLC

48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.			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 Manor Minonk LLC

48058

Report Period Beginning: 1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

Heritage Operations Group
Box 3188
Bloomington, IL 61701
()
()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,578	26	\$ 104,045	\$ 103,180	72	\$ 2,906	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	72	38	2
3	3	Housekeeping	Beds	2,578	26	0	0	72	0	3
4	4	Laundry	Beds	2,578	26	111	0	72	3	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	72	1,055	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	72	15,949	6
7	7	Other	Beds	2,578	26	0	0	72	0	7
8	9	Medical Director	Beds	2,578	26	0	0	72	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	16,650	12,036	72	465	9
10	11	Activities	Beds	2,578	26	0	0	72	0	10
11	12	Social Service	Beds	2,578	26	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,578	26	29,896	28,423	72	835	12
13	14	Program Transportation	Beds	2,578	26	0	0	72	0	13
14	15	Other	Beds	2,578	26	0	0	72	0	14
15	17	Administrative	Beds	2,578	26	0	0	72	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	72	0	16
17	19	Professional Services	Beds	2,578	26	441,112	0	72	12,320	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	72	6,953	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	72	255,286	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	72	33,298	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	72	1,251	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	72	5,356	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	72	17,957	24
25	TOTALS					\$ 12,663,368	\$ 8,998,151		\$ 353,672	25

Facility Name & ID Number Heritage Manor Minonk LLC

48058

Report Period Beginning: 1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,578	26	\$	72	\$	1
2	30	Depreciation	Beds	2,578	26	727,658	72	20,322	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		72		3
4	32	Interest	Beds	2,578	26		72		4
5	33	Real Estate Taxes	Beds	2,578	26		72		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134	72	4,416	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109	72	4,472	7
8	36	Other	Beds	2,578	26		72		8
9	38	Medically Nec Transportation	Beds	2,578	26		72		9
10	39	Ancillary Service Centers	Beds	2,578	26		72		10
11	40	Barber and Beauty Shops	Beds	2,578	26		72		11
12	41	Coffee and Gift Shops	Beds	2,578	26		72		12
13	42	Other	Beds	2,578	26		72		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,045,901	\$	\$ 29,210	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Busey Bank		x	Mortgage			\$	\$		\$ 25,743	1									
2	Busey Bank		x	Loan Fee Amortization						9,718	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Busey Bank		x	Working Capital						28,505	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 63,966	9									
B. Non-Facility Related*																				
10	Interest Income									(292)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (292)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 63,674	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 Manor Minonk LLC# 48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2017 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.)				\$	32,082 2
3. Under or (over) accrual (line 2 minus line 1).				\$	32,082 3
4. Real Estate Tax accrual used for 2018 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.				\$	32,082 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2013	<u>30,678</u>	8		
	2014	<u>31,161</u>	9		
	2015	<u>31,149</u>	10		
	2016	<u>31,892</u>	11		
	2017	<u>32,082</u>	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2017 \$ 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Minonk LLC COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 48058

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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>0607407010</u>	_____	\$ <u>12,304.12</u>	\$ <u>12,304.00</u>
2. <u>0607407011</u>	_____	\$ <u>19,777.78</u>	\$ <u>19,778.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>32,081.90</u></u>	\$ <u><u>32,082.00</u></u>

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,960 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>25,000</u>	1
2					2
3	TOTALS			\$ <u>25,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	72			\$ 1,039,908	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	1996 Improvements		1996	199,013					9
10	1997 Improvements		1997	(107,453)					10
11	1998 Improvements		1998	22,928					11
12	1999 Improvements		1999	16,328					12
13	2000 Improvements		2000	9,183					13
14	2001 Improvements		2001	3,366					14
15	2002 Improvements		2002	21,999					15
16	2003 Improvements		2003	34,768					16
17	2004 Improvements		2004	19,520					17
18	2005 Improvements		2005	15,675					18
19	2006 Improvements		2006	22,858					19
20	2007 Improvements		2007	66,306					20
21	2008 Improvements		2008	190,181					21
22	2009 Improvements		2009	63,136					22
23	2010 Improvements		2010	65,698					23
24	2011 Improvements		2011	619,556					24
25	2012 Improvements		2012	331,782					25
26									26
27	Elevator Door Restrictor		2013	6,150					27
28	Hot Water Pump		2013	3,216					28
29	Storage Tank Installation		2013	7,164					29
30	Boiler Replacement		2013	106,562					30
31	Sanitary Sewer Repair		2013	13,250					31
32	Water Heater		2013	3,770					32
33									33
34	C/O Allocation				20,322		20,322		34
35	Book Depreciation				145,986		145,986		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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38	2014	6,089						38
39	2014	30,700						39
40								40
41	2015	37,697						41
42	2015	180,553						42
43	2015	6,398						43
44								44
45	2016	5,088						45
46								46
47	2017	3,273						47
48	2017	6,185						48
49								49
50	2018							50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,050,847	\$ 166,308		\$ 166,308	\$	\$	70

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

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	\$ 577,812	\$ 36,693	\$ 36,693	\$		\$	71
72	Current Year Purchases	5,732						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 583,544	\$ 36,693	\$ 36,693	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2009 Turtletop bus	2008	\$ 60,815	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 60,815	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,720,206	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,001	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,001	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 28,168 Description: Televisions and copiers

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	151,905	\$		\$	151,905					1
2	Licensed Speech and Language Development Therapist		hrs				32,588				32,588					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs				147,074		1,052		148,126					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts						87,441		87,441					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):						16,983				16,983					13
14	TOTAL			\$		\$	348,550	\$	88,493	\$	437,043					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 Manor Minonk LLC

48058

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(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	\$ 436	\$	1
2	Cash-Patient Deposits	1,886		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	241,675		3
4	Supply Inventory (priced at <u>FIFO</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,419,161)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,175,104)	\$	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)	\$ (1,175,104)	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 92,461	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,886		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	136,406		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,413		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Bed Tax</u>	4,856		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 240,022	\$	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)	\$ 240,022	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,415,126)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,175,104)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,163,575)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,163,575)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(251,551)	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)	\$ (251,551)	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)	\$ (1,415,126)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,725,195	1
2	Discounts and Allowances for all Levels	(908,136)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,817,059	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,029,515	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,029,515	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	1,939	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	164,559	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,786	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 177,284	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	292	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 292	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,024,150	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	598,928	31
32	Health Care	1,116,392	32
33	General Administration	856,781	33
B. Capital Expense			
34	Ownership	372,033	34
C. Ancillary Expense			
35	Special Cost Centers	331,567	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,275,701	40
41	Income before Income Taxes (line 30 minus line 40)**	(251,551)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (251,551)	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 Manor Minonk LLC**

48058

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,449	1,542	\$ 53,339	\$ 34.59	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	3,481	3,703	130,377	35.21	3
4	Licensed Practical Nurses	6,159	6,552	186,333	28.44	4
5	CNAs & Orderlies	22,077	23,486	353,462	15.05	5
6	CNA Trainees		0			6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,783	2,960	71,839	24.27	8
9	Activity Director					9
10	Activity Assistants	3,842	4,087	56,359	13.79	10
11	Social Service Workers	1,679	1,786	46,365	25.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,397	14,253	165,943	11.64	15
16	Dishwashers					16
17	Maintenance Workers	4,837	5,146	63,360	12.31	17
18	Housekeepers	4,168	4,434	43,650	9.84	18
19	Laundry	3,282	3,492	35,667	10.21	19
20	Administrator	1,955	2,080	77,667	37.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,622	4,917	147,766	30.05	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)	73,731	78,438	\$ 1,432,127 *	\$ 18.26	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 4,623		35
36	Medical Director	0		36
37	Medical Records Consultant	1,782		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,321		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,804		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,530		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 54,687		50
51	Licensed Practical Nurses	768		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	\$ 55,455		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Kim Seaman</u>			\$ <u>77,667</u>	<u>Workers' Compensation Insurance</u>	\$ <u>14,855</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>8,075</u>	<u>Advertising: Employee Recruitment</u>	<u>6,726</u>	
				<u>FICA Taxes</u>	<u>109,558</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>115,402</u>	<u>(Indicate # of checks performed)</u>	<u>385</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>PR</u>	<u>7,940</u>	
				<u>Other Benefits</u>	<u>14,568</u>	<u>Dues & Subscriptions</u>	<u>4,368</u>	
				<u>Central Office Allocation</u>	<u>33,298</u>	<u>License & Fees</u>	<u>5,145</u>	
						<u>Central Office Allocation</u>	<u>6,953</u>	
						<u>Less: Public Relations Expense</u>	<u>(7,940)</u>	
						<u>Non-allowable advertising</u>	<u>(2,496)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>77,667</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>295,756</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>21,081</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ <u>0</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
								<u>3,278</u>
								<u>1,689</u>
							<u>Seminar Expense</u>	<u>1,704</u>
								<u>(1,672)</u>
							<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>4,999</u>
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Heritage Operations Group</u>	<u>Management</u>		\$ <u>148,889</u>					
<u>Legal adj to Zero</u>			<u>1,666</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>150,555</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor Minonk LLC# 48058

Report Period Beginning:

1/1/2018Ending: 12/31/2018**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. Health Care Council of Illinois
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,707
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,987
- (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: May Cocagne & King
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor - Minonk
IDPH ID# 48058
HFS Cost Report - December 31, 2018
Schedule V - Column 5 Reclassifications

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 87,441
Purchased Hospital Services	4,183
Purchased Laboratory Services	10,956
Purchased Radiology Services	1,844
Amount Reclassified to Line 39	<u>\$ 104,424</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (26,828)
Provider Assesment Fee - \$6.07	<u>(58,879)</u>
	<u>(85,707)</u>
Provider Participation Fee - Line 42	<u>85,707</u>