



Facility Name & ID Number Heritage Manor Minonk LLC

# 48058 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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	4,140	4,847	2,249	11,236	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,319		1,319	12
13	DD 16 OR LESS					13
14	TOTALS	4,140	6,166	2,249	12,555	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.77%**

**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 2,249

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.

Facility Name & ID Number Heritage Manor Minonk LLC # 48058 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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
	<b>A. General Services</b>										
1	Dietary	185,377	9,602		194,979		194,979	2,833	197,812		1
2	Food Purchase		117,013		117,013		117,013		117,013		2
3	Housekeeping	47,447	23,923		71,370		71,370	4	71,374		3
4	Laundry	36,115	9,027		45,142		45,142		45,142		4
5	Heat and Other Utilities			64,211	64,211		64,211	1,090	65,301		5
6	Maintenance	75,389	54,015	48,405	177,809		177,809	16,621	194,430		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>344,328</b>	<b>213,580</b>	<b>112,616</b>	<b>670,524</b>		<b>670,524</b>	<b>20,548</b>	<b>691,072</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,068	1,068		1,068		1,068		9
10	Nursing and Medical Records	966,666	51,923	4,574	1,023,163		1,023,163	(10,506)	1,012,657		10
10a	Therapy		320,861	34,252	355,113	(353,551)	1,562		1,562		10a
11	Activities	68,432	7,112		75,544		75,544		75,544		11
12	Social Services	45,460		2,190	47,650		47,650		47,650		12
13	CNA Training	1,214		273	1,487		1,487	782	2,269		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,081,772</b>	<b>379,896</b>	<b>42,357</b>	<b>1,504,025</b>	<b>(353,551)</b>	<b>1,150,474</b>	<b>(9,724)</b>	<b>1,140,750</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	87,447			87,447		87,447		87,447		17
18	Directors Fees										18
19	Professional Services			174,446	174,446		174,446	(161,946)	12,500		19
20	Dues, Fees, Subscriptions & Promotions			104,728	104,728	(78,441)	26,287	(13,705)	12,582		20
21	Clerical & General Office Expenses	142,493	20,328	6,644	169,465		169,465	261,081	430,546		21
22	Employee Benefits & Payroll Taxes			259,949	259,949		259,949	35,301	295,250		22
23	Inservice Training & Education			4,996	4,996		4,996	3	4,999		23
24	Travel and Seminar			6,116	6,116		6,116	(1,117)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			28,025	28,025		28,025	8,516	36,541		26
27	Other (specify):*			6,175	6,175		6,175	(6,175)			27
28	<b>TOTAL General Administration</b>	<b>229,940</b>	<b>20,328</b>	<b>591,079</b>	<b>841,347</b>	<b>(78,441)</b>	<b>762,906</b>	<b>121,958</b>	<b>884,864</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,656,040</b>	<b>613,804</b>	<b>746,052</b>	<b>3,015,896</b>	<b>(431,992)</b>	<b>2,583,904</b>	<b>132,782</b>	<b>2,716,686</b>		<b>29</b>

\*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 Manor Minonk LLC

#48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation							210,057	210,057			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,126	25,126		25,126	26,663	51,789			32
33	Real Estate Taxes							31,892	31,892			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(311,018)	4,342			34
35	Rent-Equipment & Vehicles			18,692	18,692		18,692	5,547	24,239			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			359,178	359,178		359,178	(36,859)	322,319			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			415,285	415,285	353,551	768,836	(100,367)	668,469			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					78,441	78,441		78,441			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			415,285	415,285	431,992	847,277	(100,367)	746,910			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,656,040	613,804	1,520,515	3,790,359		3,790,359	(4,444)	3,785,915			45

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

**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	(239)			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	(1,176)			17
18	Fines and Penalties				18
19	Entertainment	(7,039)			19
20	Contributions	(175)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,626)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(19,588)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (35,843)		\$	30

**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)	31,399		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 31,399		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (4,444)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Heritage Manor Minonk LLC

ID# 48058

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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		(1,626)	19	22
23				23
24		(6,000)	27	24
25		(19,588)	20	25
26				26
27		(175)	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	<b>Total</b>	(27,389)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Minonk LLC# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	2,833	0	0	0	0	0	0	0	0	2,833	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,090	0	0	0	0	0	0	0	0	1,090	5
6	Maintenance	0	0	16,621	0	0	0	0	0	0	0	0	16,621	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>20,548</b>	<b>0</b>	<b>20,548</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(10,772)	266	0	0	0	0	0	0	0	0	(10,506)	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	782	0	0	0	0	0	0	0	0	782	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(10,772)</b>	<b>1,048</b>	<b>0</b>	<b>(9,724)</b>	<b>16</b>							
	<b>C. General Administration</b>													
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	(1,626)	(172,337)	12,017	0	0	0	0	0	0	0	0	(161,946)	19
20	Fees, Subscriptions & Promotions	(19,588)	0	5,883	0	0	0	0	0	0	0	0	(13,705)	20
21	Clerical & General Office Expenses	0	0	261,081	0	0	0	0	0	0	0	0	261,081	21
22	Employee Benefits & Payroll Taxes	0	0	35,301	0	0	0	0	0	0	0	0	35,301	22
23	Inservice Training & Education	(1,176)	(34)	1,213	0	0	0	0	0	0	0	0	3	23
24	Travel and Seminar	(7,039)	0	5,922	0	0	0	0	0	0	0	0	(1,117)	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	8,516	0	0	0	0	0	0	0	0	8,516	26
27	Other (specify):*	(6,175)	0	0	0	0	0	0	0	0	0	0	(6,175)	27
28	<b>TOTAL General Administration</b>	<b>(35,604)</b>	<b>(172,371)</b>	<b>329,933</b>	<b>0</b>	<b>121,958</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(35,604)</b>	<b>(183,143)</b>	<b>351,529</b>	<b>0</b>	<b>132,782</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Minonk LLC# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	188,597	0	21,460	0	0	0	0	0	0	0	210,057	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(239)	25,654	0	1,248	0	0	0	0	0	0	0	26,663	32
33	Real Estate Taxes	0	31,892	0	0	0	0	0	0	0	0	0	31,892	33
34	Rent-Facility & Grounds	0	(315,360)	0	4,342	0	0	0	0	0	0	0	(311,018)	34
35	Rent-Equipment & Vehicles	0	0	0	5,547	0	0	0	0	0	0	0	5,547	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	(239)	(69,217)	0	32,597	0	0	0	0	0	0	0	(36,859)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(100,367)	0	0	0	0	0	0	0	0	0	(100,367)	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	<b>TOTAL Special Cost Centers</b>	0	(100,367)	0	0	0	0	0	0	0	0	0	(100,367)	44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	(35,843)	(352,727)	351,529	32,597	0	0	0	0	0	0	0	(4,444)	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:		
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)		
1	V	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (10,772)	\$	(10,772)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(34)		(34)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(100,367)		(100,367)	3
4	V	19 Adjustment for Related Organization	172,337	Heritage Operations Group, LLC				(172,337)	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		31,892		31,892	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		23,263		23,263	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		188,597		188,597	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,391		2,391	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 487,697			\$ 134,970	\$ *	(352,727)	14

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

Facility Name &amp; ID Number

Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

## 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		\$	\$ 2,833	15
16	V	2 Food Purchase					0	16
17	V	3 Housekeeping					4	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,090	19
20	V	6 Maintenance					16,621	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					266	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					782	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					12,017	31
32	V	20 Fees, Subscription, Promotions					5,883	32
33	V	21 Clerical & General Office Expenses					261,081	33
34	V	22 Employee Benefits & Payroll Taxes					35,301	34
35	V	23 Inservice Training & Education					1,213	35
36	V	24 Travel and Seminar					5,922	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					8,516	38
39	Total		\$			\$	0	\$ * 351,529 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						21,460	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						1,248	18	
19	V	33 Real Estate Taxes							19	
20	V	34 Rent-Facility & Grounds						4,342	20	
21	V	35 Rent-Equipment & Vehicles						5,547	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	\$ *	32,597	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: 1/1/2017 Ending: 12/31/2017

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.	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 Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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	1	Dietary	Beds	2,578	26	\$ 101,433	\$ 109,431	72	\$ 2,833	1
2	2	Food Purchase	Beds	2,578	26	0	0	72	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	72	4	3
4	4	Laundry	Beds	2,578	26	16	0	72	0	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	72	1,090	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	72	16,621	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	9,542	8,241	72	266	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	27,991	27,014	72	782	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	430,283	0	72	12,017	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	72	5,883	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	72	261,081	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	72	35,301	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	72	1,213	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	72	5,922	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	72	8,516	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 351,529	25

Facility Name & ID Number Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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

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	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	768,393	72	21,460	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		72		3
4	32	Interest	Beds	2,578	26	44,696	72	1,248	4
5	33	Real Estate Taxes	Beds	2,578	26		72		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	72	4,342	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	72	5,547	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					\$ 1,167,144	\$	\$ 32,597	25

Facility Name & ID Number

Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of America		x	Mortgage			\$	\$		\$ 23,263	1									
2	Bank of America		x	Loan Fee Amortization						2,391	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	Bank of America		x	Working Capital						25,126	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$		\$ 50,780	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(239)	10									
11											11									
12	Allocated Corporate									1,248	12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 1,009	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$ 51,789	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.)

**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 2016 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.)		\$	<b>31,892</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>31,892</b>	3
4. Real Estate Tax accrual used for 2017 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>31,892</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	<b>30,973</b>	8	
	2013	<b>30,678</b>	9	
	2014	<b>31,161</b>	10	
	2015	<b>31,149</b>	11	
	2016	<b>31,892</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

**2016 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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>0607407010</u>	_____	\$ <u>12,231.24</u>	\$ <u>12,231.00</u>
2. <u>0607407011</u>	_____	\$ <u>19,660.74</u>	\$ <u>19,661.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>31,891.98</u></u>	\$ <u><u>31,892.00</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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 Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, Use, Square Feet, Year Acquired, \$ 25,000, 1. Row 2: 2, Use, Square Feet, Year Acquired, \$, 2. Row 3: 3, TOTALS, Square Feet, Year Acquired, \$ 25,000, 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
<b>Improvement Type**</b>									
9	Smoke Detectors (45)		1998	3,267					9
10	Compressor		1998	1,047					10
11	Generator		1998	12,140					11
12	A/C Repair		1998	1,518					12
13	Plumbing Repair		1998	4,956					13
14									14
15	Water Heater		1996	2,603					15
16	Resident Room Renovating		1996	8,483					16
17	Exterior Painting & Renovation		1996	4,806					17
18	Nurse Call System		1996	3,803					18
19	Garbage Disposal		1996	867					19
20	Boiler Repair		1996	4,436					20
21	Receptionist Work Area Renovation		1996	1,260					21
22	Hot Water Heater		1996	505					22
23	Exterior Signage		1996	1,680					23
24	Interior Rehab		1996	146,288					24
25	Interior Rehab		1996	22,963					25
26	Code Alert System		1996	1,319					26
27									27
28	Interior Rehab		1997	33,578					28
29	Interior Rehab		1997	168					29
30	Building Purchase Offset			(141,199)					30
31									31
32									32
33	C/O Allocation				21,460		21,460		33
34	Book Depreciation				147,074		147,074		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 &amp; ID Number Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Door Alarm System	1999	\$ 10,116	\$		\$	\$	\$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005							65
66		2005	6,106						66
67			2,957						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,275,235	\$ 168,534		\$ 168,534	\$	\$	70

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

Facility Name &amp; ID Number Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,275,235	\$ 168,534		\$ 168,534	\$	\$	1
2	Climate Control	2006	1,299						2
3	Shower Faucet	2006	444						3
4	Sprinkler main line	2006	6,672						4
5	Compressor	2006	1,580						5
6	Corridor Rehab	2006	5,855						6
7	Rooftop A/C	2006	8,235						7
8	Audit ADJ 2006	2006	(1,227)						8
9	Fire Alarm	2007	39,698						9
10	Chiller	2007	11,569						10
11	Bearing Assembly	2007	1,109						11
12	Sprinkler	2007	2,180						12
13	HVAC	2007	876						13
14	Landscaping	2007	9,585						14
15	Thermostat	2007	7,722						15
16	Audit ADJ 2007	2007	(6,433)						16
17	Nurse Call System	2008	125,184						17
18	Soffit & Facia	2008	14,880						18
19	Water Heater	2008	9,193						19
20	Wonderguard	2008	8,777						20
21	Wireless phone system	2008	22,250						21
22	Cables for Nurse Call system	2008	9,897						22
23									23
24	Shower Faucet	2009	6,569						24
25	Front Doors	2009	6,370						25
26	Sprinkler System	2009	43,180						26
27	Water Heater	2009	7,017						27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,617,716	\$ 168,534		\$ 168,534	\$	\$	34

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

Facility Name &amp; ID Number Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,617,716	\$ 168,534		\$ 168,534	\$	\$	1
2									2
3	Air Compressor	2010	2,800						3
4	Remodel: Paint resident rooms/labor & flooring	2010	50,213						4
5	Data System	2010	9,854						5
6	Garage Heater	2010	2,831						6
7									7
8	Facility Remodel: Flooring, Paint, lighting & labor	2011	529,930						8
9	A/C chiller	2011	75,594						9
10	Water Heater	2011	6,875						10
11	Sprinkler Heads	2011	7,157						11
12									12
13	Facility Remodel: Flooring, Paint, lighting & labor	2012	315,942						13
14	Therapy Sewer line	2012	13,193						14
15	Lighting Upgrade	2012	2,647						15
16									16
17	Elevator Door Restrictor	2013	6,150						17
18	Hot Water Pump	2013	3,216						18
19	Storage Tank Installation	2013	7,164						19
20	Boiler Replacement	2013	106,562						20
21	Sanitary Sewer Repair	2013	13,250						21
22	Water Heater	2013	3,770						22
23									23
24	Install Split System - Therapy Room	2014	6,089						24
25	Install New Windows	2014	30,700						25
26									26
27	Install electronic security - (6) doors	2015	37,697						27
28	Replace fire sprinkler system	2015	180,553						28
29	Install new water heater; disconnect and remove old heater	2015	6,398						29
30									30
31	Replace fire alarm control panel	2016	5,088						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,041,389	\$ 168,534		\$ 168,534	\$	\$	34

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

Facility Name & ID Number Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 12C, Carried Forward		\$ 3,041,389	\$ 168,534		\$ 168,534	\$	\$	1
2									2
3	Install hot water pump motor	2017	3,273						3
4	Replace water mixing valve	2017	6,185						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									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)		\$ 3,050,847	\$ 168,534		\$ 168,534	\$	\$	34

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

Facility Name & ID Number Heritage Manor Minonk LLC

# 48058

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$ 41,523	\$ 41,523	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 577,812	\$ 41,523	\$ 41,523	\$		\$	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)	\$ 3,714,474	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 210,057	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 210,057	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 Manor Minonk LLC

# 48058

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 18,692

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	<b>TOTAL</b>		\$	\$	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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		273		273
3	Classroom Wages (a)		1,214		1,214
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 1,487	\$	\$ 1,487
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	1,487		

**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)	
<b>TOTAL TRAINED</b>	

- (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	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	\$		\$ 197,299	\$		\$ 197,299	1
2	Licensed Speech and Language Development Therapist		hrs			43,199			43,199	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			174,787	1,562		176,349	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				319,299		319,299	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					34,252			34,252	13
14	TOTAL			\$		\$ 449,537	\$ 320,861		\$ 770,398	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 576	\$	1
2	Cash-Patient Deposits	4,074		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	543,864		3
4	Supply Inventory (priced at FIFO )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,049		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,503,574)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (952,011)	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (952,011)	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 37,776	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,074		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,558		30
31	Accrued Taxes Payable (excluding real estate taxes)	811		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Bed Tax</u>	8,346		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 211,565	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 211,565	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,163,576)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (952,011)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(877,808)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(877,808)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(285,768)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(285,768)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,163,576)</b>	<b>24</b> *

\* 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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,017,268	1
2	Discounts and Allowances for all Levels	(1,555,814)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,461,454	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,389,692	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,389,692	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,309	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	625,091	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	25,806	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 653,206	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	239	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 239	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,504,591	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	670,524	31
32	Health Care	1,504,025	32
33	General Administration	841,347	33
<b>B. Capital Expense</b>			
34	Ownership	359,178	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	415,285	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,790,359	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(285,768)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (285,768)	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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:

1/1/2017

Ending:

12/31/2017

**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	1,778	1,872	\$ 62,180	\$ 33.22	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,983	7,350	247,426	33.66	3
4	Licensed Practical Nurses	5,452	5,739	162,294	28.28	4
5	CNAs & Orderlies	25,960	27,326	420,960	15.41	5
6	CNA Trainees	137	144	1,214	8.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,957	4,166	73,806	17.72	8
9	Activity Director					9
10	Activity Assistants	5,611	5,906	68,432	11.59	10
11	Social Service Workers	1,745	1,837	45,460	24.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,821	15,601	185,377	11.88	15
16	Dishwashers					16
17	Maintenance Workers	4,776	5,028	75,389	14.99	17
18	Housekeepers	4,634	4,878	47,447	9.73	18
19	Laundry	3,509	3,694	36,115	9.78	19
20	Administrator	1,748	1,840	87,447	47.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,597	5,892	142,493	24.18	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)	86,708	91,273	\$ 1,656,040 *	\$ 18.14	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	1,068		36
37	Medical Records Consultant	2,000		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,216		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	2,190		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 7,474		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
<u>Kim Seaman</u>			\$ <u>87,447</u>	<u>Workers' Compensation Insurance</u>	\$ <u>34,281</u>	<u>IDPH License Fee</u>	\$		
				<u>Unemployment Compensation Insurance</u>	<u>12,027</u>	<u>Advertising: Employee Recruitment</u>	<u>2,963</u>		
				<u>FICA Taxes</u>	<u>126,687</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>78,144</u>	(Indicate # of checks performed _____)	<u>528</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>87,447</u></b>	<u>Other Benefits</u>	<u>8,810</u>	<u>PR</u>	<u>6,821</u>		
<b>(List each licensed administrator separately.)</b>				<u>Central Office Allocation</u>	<u>35,301</u>	<u>Dues &amp; Subscriptions</u>	<u>4,868</u>		
						<u>License &amp; Fees</u>	<u>1,336</u>		
						<u>Central Office Allocation</u>	<u>5,883</u>		
						<u>Less: Public Relations Expense</u>	<u>(6,821)</u>		
						<u>Non-allowable advertising</u>	<u>(2,996)</u>		
						<u>Yellow page advertising</u>	( )		
						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ <u>12,582</u></b>		
				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ <u>295,250</u></b>				
B. Administrative - Other			Amount	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>Out-of-State Travel</u>	\$	
							<u>In-State Travel</u>		
								<u>5,031</u>	
								<u>47</u>	
							<u>Seminar Expense</u>	<u>1,038</u>	
								<u>(1,117)</u>	
							<u>Entertainment Expense</u>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>	<b>TOTAL</b>			<b>\$</b>		
<b>(Attach a copy of any management service agreement)</b>							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	<b>\$ <u>4,999</u></b>	
C. Professional Services			Amount						
Vendor/Payee	Type								
<u>Heritage Operations Group</u>	<u>Mgt services</u>		<u>172,629</u>						
<u>ADP</u>	<u>Payroll Tax Processing</u>		<u>191</u>						
<u>Legal adj to Zero</u>			<u>1,626</u>						
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>174,446</u></b>						
<b>(For legal fee disclosure, see page 39 of instructions)</b>									

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Heritage Manor Minonk LLC# 48058Report Period Beginning: 1/1/2017Ending: 12/31/2017**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 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. \$ 78,441  
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? \_\_\_\_\_ Indicate the amount. \$ 1,875
- (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

Heritage Manor - Minonk  
IDPH ID# 48058  
HFS Cost Report - December 31, 2017  
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	319,299
Purchased Hospital Services		5,857
Purchased Laboratory Services		25,933
Purchased Radiology Services		<u>2,462</u>
Amount Reclassified to Line 39	\$	<u><u>353,551</u></u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	26,828
Provider Assessment Fee - \$6.70		<u>51,613</u>
Amount Reclassified to Line 42		<u><u>78,441</u></u>