

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 48058

Facility Name: Heritage Manor Minonk, LLC.

Address: 201 Locust Minonk 61760
Number City Zip Code

County: Woodford

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

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

x

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

x

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Craig Ater

(Title) Exec VP & CFO

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor Minonk, LLC.

48058 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	49	17,885	1
2				2
3				3
4				4
5	23	23	8,395	5
6				6
7	72	72	26,280	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,806	4,589	1,857	14,252	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,271		3,271	12
13	DD 16 OR LESS					13
14	TOTALS	7,806	7,860	1,857	17,523	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.68%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

none

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

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

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 July 2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date July 2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 1,857

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ 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: 01/01/11 Ending: 12/31/11
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	172,811	9,785		182,596		182,596	4,039	186,635			1
2	Food Purchase		150,565		150,565		150,565	14	150,579			2
3	Housekeeping	79,709	15,763		95,472		95,472	6	95,478			3
4	Laundry	36,807	9,680		46,487		46,487	4	46,491			4
5	Heat and Other Utilities			83,108	83,108		83,108	1,423	84,531			5
6	Maintenance	60,732	78,087	37,771	176,590		176,590	10,471	187,061			6
7	Other (specify):*											7
8	TOTAL General Services	350,059	263,880	120,879	734,818		734,818	15,957	750,775			8
	B. Health Care and Programs											
9	Medical Director			1,079	1,079		1,079	58	1,137			9
10	Nursing and Medical Records	960,716	53,054	6,668	1,020,438		1,020,438		1,020,438			10
10a	Therapy		154,373	238,139	392,512	(168,648)	223,864	48,004	271,868			10a
11	Activities	61,267	3,762		65,029		65,029		65,029			11
12	Social Services	35,197		1,682	36,879		36,879		36,879			12
13	CNA Training	4,799	240		5,039		5,039	579	5,618			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,061,979	211,429	247,568	1,520,976	(168,648)	1,352,328	48,641	1,400,969			16
	C. General Administration											
17	Administrative	85,579			85,579		85,579	61,470	147,049			17
18	Directors Fees											18
19	Professional Services			139,725	139,725		139,725	(132,377)	7,348			19
20	Dues, Fees, Subscriptions & Promotions			44,726	44,726	(26,828)	17,898	(5,635)	12,263			20
21	Clerical & General Office Expenses	106,578	16,975	4,971	128,524		128,524	135,628	264,152			21
22	Employee Benefits & Payroll Taxes			301,897	301,897		301,897	28,518	330,415			22
23	Inservice Training & Education			504	504		504	354	858			23
24	Travel and Seminar			7,691	7,691		7,691	(5,692)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,151	30,151		30,151	8,357	38,508			26
27	Other (specify):*			50	50		50		50			27
28	TOTAL General Administration	192,157	16,975	529,715	738,847	(26,828)	712,019	90,623	802,642			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,604,195	492,284	898,162	2,994,641	(195,476)	2,799,165	155,221	2,954,386			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 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	
	D. Ownership											
30	Depreciation							119,352	119,352			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,782	4,782		4,782	51,673	56,455			32
33	Real Estate Taxes							31,446	31,446			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(314,673)	687			34
35	Rent-Equipment & Vehicles			577	577		577	670	1,247			35
36	Other (specify):*											36
37	TOTAL Ownership			320,719	320,719		320,719	(111,532)	209,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					168,648	168,648		168,648			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,828	26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					195,476	195,476		195,476			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,604,195	492,284	1,218,881	3,315,360		3,315,360	43,689	3,359,049			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(43)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(549)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,524)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,190)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(9,068)	20		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)	\$ (24,374)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	68,063		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 68,063		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 43,689		37

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

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

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

ID#48058

Report Period Beginning:01/01/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(549)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,190)	19	22
23				23
24		0	27	24
25		(9,068)	20	25
26				26
27				27
28				28
29			33	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	(11,807)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Minonk, LLC. # 48058 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	4,039	0	0	0	0	0	0	0	0	4,039	1
2	Food Purchase	0	0	14	0	0	0	0	0	0	0	0	14	2
3	Housekeeping	0	0	6	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	4	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	1,423	0	0	0	0	0	0	0	0	1,423	5
6	Maintenance	0	0	10,471	0	0	0	0	0	0	0	0	10,471	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	15,957	0	0	0	0	0	0	0	0	15,957	8
	B. Health Care and Programs													
9	Medical Director	0	0	58	0	0	0	0	0	0	0	0	58	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	48,004	0	0	0	0	0	0	0	0	0	48,004	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	579	0	0	0	0	0	0	0	0	579	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	48,004	637	0	0	0	0	0	0	0	0	48,641	16
	C. General Administration													
17	Administrative	0	0	61,470	0	0	0	0	0	0	0	0	61,470	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,190)	(137,535)	7,348	0	0	0	0	0	0	0	0	(132,377)	19
20	Fees, Subscriptions & Promotions	(9,617)	0	3,982	0	0	0	0	0	0	0	0	(5,635)	20
21	Clerical & General Office Expenses	0	0	135,628	0	0	0	0	0	0	0	0	135,628	21
22	Employee Benefits & Payroll Taxes	0	0	28,518	0	0	0	0	0	0	0	0	28,518	22
23	Inservice Training & Education	0	0	354	0	0	0	0	0	0	0	0	354	23
24	Travel and Seminar	(12,524)	0	6,832	0	0	0	0	0	0	0	0	(5,692)	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	8,357	0	0	0	0	0	0	0	0	8,357	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,331)	(137,535)	252,489	0	0	0	0	0	0	0	0	90,623	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,331)	(89,531)	269,083	0	0	0	0	0	0	0	0	155,221	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Minonk, LLC. # 48058 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	110,868	0	8,484	0	0	0	0	0	0	0	119,352	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43)	51,281	0	435	0	0	0	0	0	0	0	51,673	32
33	Real Estate Taxes	0	31,446	0	0	0	0	0	0	0	0	0	31,446	33
34	Rent-Facility & Grounds	0	(315,360)	0	687	0	0	0	0	0	0	0	(314,673)	34
35	Rent-Equipment & Vehicles	0	0	0	670	0	0	0	0	0	0	0	670	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(43)	(121,765)	0	10,276	0	0	0	0	0	0	0	(111,532)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(24,374)	(211,296)	269,083	10,276	0	0	0	0	0	0	0	43,689	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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>See Page 25</u>				

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			\$			\$		1
2	V	<u>10a</u>	<u>Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>48,004</u>	<u>48,004</u>	2
3	V								3
4	V	<u>19</u>	<u>Adjustment for Related Organization</u>	<u>137,535</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(137,535)</u>	4
5	V								5
6	V	<u>34</u>	<u>Adjustment for Related Organization</u>	<u>315,360</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(315,360)</u>	6
7	V	<u>33</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>31,446</u>	<u>31,446</u>	7
8	V	<u>32</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>45,800</u>	<u>45,800</u>	8
9	V	<u>30</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>110,868</u>	<u>110,868</u>	9
10	V	<u>32</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,481</u>	<u>5,481</u>	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 452,895			\$ 241,599	\$ * (211,296)	14

* 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	1	Dietary	\$	Heritage Enterprises, Inc.		\$	4,039	15
16	V	2	Food Purchase					14	16
17	V	3	Housekeeping					6	17
18	V	4	Laundry					4	18
19	V	5	Heat & Other Utilities					1,423	19
20	V	6	Maintenance					10,471	20
21	V	7	Other					0	21
22	V	9	Medical Director					58	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					579	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					61,470	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					7,348	31
32	V	20	Fees, Subscription, Promotions					3,982	32
33	V	21	Clerical & General Office Expenses					135,628	33
34	V	22	Employee Benefits & Payroll Taxes					28,518	34
35	V	23	Inservice Training & Education					354	35
36	V	24	Travel and Seminar					6,832	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,357	38
39	Total			\$			\$	0	\$ * 269,083 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 Enterprises, Inc.		\$	0	15
16	V	30	Depreciation					8,484	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					435	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					687	20
21	V	35	Rent-Equipment & Vehicles					670	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	\$ * 10,276 39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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.	Member		100.00					\$ 0		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: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	2,735	26	\$ 153,442	\$ 153,115	72	\$ 4,039	1
2	2	Food Purchase	Beds	2,735	26	520	0	72	14	2
3	3	Housekeeping	Beds	2,735	26	215	0	72	6	3
4	4	Laundry	Beds	2,735	26	151	0	72	4	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	72	1,423	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	72	10,471	6
7	7	Other	Beds	2,735	26	0	0	72	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	72	58	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	72	0	9
10	11	Activities	Beds	2,735	26	0	0	72	0	10
11	12	Social Service	Beds	2,735	26	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	72	579	12
13	14	Program Transportation	Beds	2,735	26	0	0	72	0	13
14	15	Other	Beds	2,735	26	0	0	72	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	72	61,470	15
16	18	Directors Fees	Beds	2,735	26	0	0	72	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	72	7,348	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	72	3,982	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	5,151,979	4,517,846	72	135,628	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,083,278	0	72	28,518	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	72	354	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	72	6,832	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	72	8,357	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 269,083	25

Facility Name & ID Number Heritage Manor Minonk, LLC. # 48058 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	2,735	26	\$		72	\$	1
2	30	Depreciation	Beds	2,735	26	322,258		72	8,484	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			72		3
4	32	Interest	Beds	2,735	26	16,517		72	435	4
5	33	Real Estate Taxes	Beds	2,735	26			72		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		72	687	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		72	670	7
8	36	Other	Beds	2,735	26			72		8
9	38	Medically Nec Transportation	Beds	2,735	26			72		9
10	39	Ancillary Service Centers	Beds	2,735	26			72		10
11	40	Barber and Beauty Shops	Beds	2,735	26			72		11
12	41	Coffee and Gift Shops	Beds	2,735	26			72		12
13	42	Other	Beds	2,735	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					\$ 390,316	\$		\$ 10,276	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	Bank of America		xx	Mortgage			\$	847,884	03/2016	variable	\$ 45,800	1
2	Bank of America		xx	Loan Fees							5,481	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							4,782	6
7												7
8												8
9	TOTAL Facility Related						\$	847,884			\$ 56,063	9
	B. Non-Facility Related*											
10	Interest Income										(43)	10
11	Allocated Corporate										435	11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ 392	14
15	TOTALS (line 9+line14)						\$	847,884			\$ 56,455	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

HFS 3745 (N-4-99)

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 2010 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	31,446	2
3. Under or (over) accrual (line 2 minus line 1).			\$	31,446	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	31,446	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	26,483	8	
		2007	34,546	9	
		2008	34,664	10	
		2009	37,460	11	
		2010	31,446	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 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 2010 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 2010.

(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>0607407011</u>	<u>nursing home</u>	\$ <u>19,386.00</u>	\$ <u>19,386.00</u>
2. <u>0607407010</u>		\$ <u>12,060.00</u>	\$ <u>12,060.00</u>
3. <u></u>		\$ <u></u>	\$ <u></u>
4. <u></u>		\$ <u></u>	\$ <u></u>
5. <u></u>		\$ <u></u>	\$ <u></u>
6. <u></u>		\$ <u></u>	\$ <u></u>
7. <u></u>		\$ <u></u>	\$ <u></u>
8. <u></u>		\$ <u></u>	\$ <u></u>
9. <u></u>		\$ <u></u>	\$ <u></u>
10. <u></u>		\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>31,446.00</u></u>	\$ <u><u>31,446.00</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 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,560

B. General Construction Type: Exterior brickFrame woodNumber 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				\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	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			1997	(141,199)						30
31											31
32											32
33	C/O Allocation							8,484	8,484		33
34	Book Depreciation					78,031		78,031			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

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	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	Exterior Doors	2005	6,106						66
67	Sprinkler Repair	2005	2,957						67
68	Glass Door	2005							68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,275,235	\$ 78,031		\$ 86,515	\$ 8,484	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,275,235	\$ 78,031		\$ 86,515	\$ 8,484	\$	1
2	Climate Control	2006	1,299						2
3	Shower Faucet	2006	444						3
4	Sprinkler main line	2006	6,672						4
5	Compressor	2006	1,580						5
6	Corridor Rehab	2006	5,855						6
7	Rooftop A/C	2006	8,235						7
8	Audit ADJ 2006	2006	(1,227)						8
9	Fire Alarm	2007	39,698						9
10	Chiller	2007	11,569						10
11	Bearing Assembly	2007	1,109						11
12	Sprinkler	2007	2,180						12
13	HVAC	2007	876						13
14	Landscaping	2007	9,585						14
15	Thermostat	2007	7,722						15
16	Audit ADJ 2007	2007	(6,433)						16
17	Nurse Call System	2008	125,184						17
18	Soffit & Facia	2008	14,880						18
19	Water Heater	2008	9,193						19
20	Wonderguard	2008	8,777						20
21	Wireless phone system	2008	22,250						21
22	Cables for Nurse Call system	2008	9,897						22
23									23
24	Shower Faucet	2009	6,569						24
25	Front Doors	2009	6,370						25
26	Sprinkler System	2009	43,180						26
27	Water Heater	2009	7,017						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,617,716	\$ 78,031		\$ 86,515	\$ 8,484	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,617,716	\$ 78,031		\$ 86,515	\$ 8,484	\$	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									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)		\$ 2,302,970	\$ 78,031		\$ 86,515	\$ 8,484	\$	34

**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	\$380,168	\$32,837	\$32,837	\$		\$	71
72	Current Year Purchases	208,110						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$588,278	\$32,837	\$32,837	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets			1	2
		Reference	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)	\$2,916,248	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$110,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$119,352	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,484	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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: \$577
- Description:
- (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

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. /2012 \$

13. /2013 \$

14. /2014 \$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

☐
☐
☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

☐
☐

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		240		240
3	Classroom Wages (a)				
4	Clinical Wages (b)		4,799		4,799
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,039	\$	\$ 5,039
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,039			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 109,657	\$		\$ 109,657	1
2	Licensed Speech and Language Development Therapist		hrs			10,266			10,266	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			102,240	1,701		103,941	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				152,672		152,672	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					15,976			15,976	13
14	TOTAL			\$		\$ 238,139	\$ 154,373		\$ 392,512	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,268	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	307,225		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,004		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(260,684)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 61,813	\$	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)	\$ 61,813	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,918	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,161		30
31	Accrued Taxes Payable (excluding real estate taxes)	(388)		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 218,691	\$	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)	\$ 218,691	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (156,878)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 61,813	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$20,114	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$20,114	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(176,992)	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)	\$(176,992)	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)	\$(156,878)	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,973,941	1
2	Discounts and Allowances for all Levels	(885,547)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,088,394	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	754,974	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 754,974	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	86	12
13	Barber and Beauty Care	2,477	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	276,176	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	16,218	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 294,957	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43	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)	\$ 3,138,368	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	734,818	31
32	Health Care	1,520,976	32
33	General Administration	738,847	33
	B. Capital Expense		
34	Ownership	320,719	34
	C. Ancillary Expense		
35	Special Cost Centers		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)*	\$ 3,315,360	40
41	Income before Income Taxes (line 30 minus line 40)**	(176,992)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (176,992)	43

* 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.

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	1,904	2,256	\$66,170	\$29.33	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,689	7,983	217,404	27.23	3
4	Licensed Practical Nurses	5,008	5,173	116,850	22.59	4
5	CNAs & Orderlies	39,183	41,191	516,152	12.53	5
6	CNA Trainees	475	475	4,799	10.10	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,790	1,790	44,140	24.66	8
9	Activity Director					9
10	Activity Assistants	5,006	5,249	61,267	11.67	10
11	Social Service Workers	1,681	1,791	35,197	19.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,313	15,871	172,811	10.89	15
16	Dishwashers					16
17	Maintenance Workers	4,145	4,194	60,732	14.48	17
18	Housekeepers	6,586	6,887	79,709	11.57	18
19	Laundry	3,603	3,724	36,807	9.88	19
20	Administrator	1,900	2,080	85,579	41.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,647	6,007	106,578	17.74	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)	99,930	104,671	\$1,604,195 *	\$15.33	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		1,079		36
37	Medical Records Consultant		1,760		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,320		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		1,682		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$8,841		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		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
Kim Seaman			\$ 85,579	Workers' Compensation Insurance		\$ 37,665	IDPH License Fee	\$ 0
				Unemployment Compensation Insurance		20,106	Advertising: Employee Recruitment	2,339
				FICA Taxes		122,721	Health Care Worker Background Check	
				Employee Health Insurance		110,531	(Indicate # of checks performed)	590
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
						0		5,863
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		10,874	Dues & Subscriptions	5,074
(List each licensed administrator separately.)				Central Office Allocation		28,518	License & Fees	827
							Central Office Allocation	3,982
B. Administrative - Other							Less: Public Relations Expense	(5,863)
Description			Amount				Non-allowable advertising	(549)
			\$				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,		\$ 330,415		TOTAL (agree to Sch. V,
(Attach a copy of any management service agreement)				line 22, col.8)				line 20, col. 8)
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgt		\$ 137,535			\$	Out-of-State Travel	\$
			0					
			0					
							In-State Travel	
								6,102
								334
							Seminar Expense	1,255
							Central Office	(5,692)
Legal adj to Zero			2,190				Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	\$ 1,999
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. Illinois Health Care Association

(3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes

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

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

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

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES xx NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor Minonk 38364 07/2006

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 26,828
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? yes 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. \$ 6,833

(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. \$ _____

(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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees

FACILITY		STATE
Owned SNFs		LICENSE
		NUMBER
Heritage Health - South, LLC		48843
Heritage Health - Bloomington, LLC		48157
Heritage Health - Carlinville, LLC		48850
Heritage Health - Chillicothe, LLC		48868
Heritage Health - Dwight, LLC		50492
Heritage Health - Elgin, LLC		48132
Heritage Health - El Paso, LLC		48124
Heritage Health - Gibson City, LLC		48116
Heritage Health - Gillespie, LLC		48892
Heritage Health - LaSalle, LLC		51276
Heritage Health - Litchfield, LLC		48900
Heritage Health - Mendota, LLC		48108
Heritage Health - Minonk, LLC		48058
Heritage Health - Mt. Sterling, LLC		48041
Heritage Health - Mt. Zion, LLC		48074
Heritage Health - Normal, LLC		48082
Heritage Health - Pana, LLC		48884
Heritage Health - Peru, LLC		48090
Heritage Health - Staunton, LLC		48876
Heritage Health - Streator, LLC		48066
Barton W. Stone Jacksonville, LLC		48918
Danville Joint Ventures, LLC d/b/aColonial Manor		42168
Heritage Health - Springfield		41699
Cotillion Ridge		45138
Country Health		7880
Mason City Area NH		34256
St. Clara's Manor		50724
Vonderlieth Living Center		19976