

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0053405 Facility Name: Heritage Health Walnut Address: 308 South Second St Walnut 61376 County: Bureau Telephone Number: 815 379-2131 Fax # () HFS ID Number: Date of Initial License for Current Owners: Jan 2015 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: Dave Underwood Telephone Number: 309 823-7135 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) David M Underwood (Title) EVP & 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
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Facility Name & ID NumberHeritage Health Walnut

#0053405Report Period Beginning:01/01/16Ending:12/31/16

III. STATISTICAL DATA

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

	1	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	62	Skilled (SNF)	62	22,692	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,692	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	10,427	6,029	1,698	18,154	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,427	6,029	1,698	18,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)80.00%

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?
YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YESNOX

I. On what date did you start providing long term care at this location?
Date startedJan 2015

J. Was the facility purchased or leased after January 1, 1978?
YESXDateJan 2015NONO

K. Was the facility certified for Medicare during the reporting year?
YESXNONOIf YES, enter number of beds certifiedand days of care provided1,698

Medicare IntermediaryWPS

IV. ACCOUNTING BASIS

MODIFIED
ACCRUALX
CASH*
CASH*

Is your fiscal year identical to your tax year?YESXNONO

Tax Year:Fiscal Year:

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

Facility Name & ID Number **Heritage Health Walnut** # **0053405** Report Period Beginning: **01/01/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	173,219	8,862		182,081		182,081	3,243	185,324			1
2	Food Purchase		130,260		130,260		130,260		130,260			2
3	Housekeeping	59,433	16,080		75,513		75,513	23	75,536			3
4	Laundry	51,433	9,590		61,023		61,023		61,023			4
5	Heat and Other Utilities			53,634	53,634		53,634	1,008	54,642			5
6	Maintenance	66,126	58,940	40,501	165,567		165,567	13,570	179,137			6
7	Other (specify):*											7
8	TOTAL General Services	350,211	223,732	94,135	668,078		668,078	17,844	685,922			8
	B. Health Care and Programs											
9	Medical Director			8,388	8,388		8,388		8,388			9
10	Nursing and Medical Records	982,016	53,629	6,239	1,041,884		1,041,884	(11,413)	1,030,471			10
10a	Therapy		300,561	18,378	318,939	(317,617)	1,322		1,322			10a
11	Activities	47,451	9,713		57,164		57,164		57,164			11
12	Social Services	75,108		2,140	77,248		77,248		77,248			12
13	CNA Training							799	799			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,104,575	363,903	35,145	1,503,623	(317,617)	1,186,006	(10,614)	1,175,392			16
	C. General Administration											
17	Administrative	82,080			82,080		82,080		82,080			17
18	Directors Fees											18
19	Professional Services			169,109	169,109		169,109	(154,630)	14,479			19
20	Dues, Fees, Subscriptions & Promotions			177,249	177,249	(137,416)	39,833	(24,280)	15,553			20
21	Clerical & General Office Expenses	102,551	13,788	5,671	122,010		122,010	189,392	311,402			21
22	Employee Benefits & Payroll Taxes			271,047	271,047		271,047	25,560	296,607			22
23	Inservice Training & Education			4,575	4,575		4,575	783	5,358			23
24	Travel and Seminar			6,802	6,802		6,802	(1,803)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			33,039	33,039		33,039	10,722	43,761			26
27	Other (specify):*			(4,392)	(4,392)		(4,392)	4,392				27
28	TOTAL General Administration	184,631	13,788	663,100	861,519	(137,416)	724,103	50,136	774,239			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,639,417	601,423	792,380	3,033,220	(455,033)	2,578,187	57,366	2,635,553			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							72,415	72,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,151	28,151		28,151	50,074	78,225			32
33	Real Estate Taxes							34,043	34,043			33
34	Rent-Facility & Grounds			272,480	272,480		272,480	(267,730)	4,750			34
35	Rent-Equipment & Vehicles			3,498	3,498		3,498	5,773	9,271			35
36	Other (specify):*											36
37	TOTAL Ownership			304,129	304,129		304,129	(105,425)	198,704			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			343,653	343,653	317,617	661,270	(41,915)	619,355			39
40	Barber and Beauty Shops			11,177	11,177		11,177		11,177			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					137,416	137,416		137,416			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			354,830	354,830	455,033	809,863	(41,915)	767,948			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,639,417	601,423	1,451,339	3,692,179		3,692,179	(89,974)	3,602,205			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				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	(46)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,849)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,533)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	4,392			24
25	Fund Raising, Advertising and Promotional	(30,470)			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)	\$ (41,506)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(48,468)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (48,468)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (89,974)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(9,533)	19	22
23				23
24		4,392	27	24
25		(30,470)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,611)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Walnut # 0053405 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	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	3,243	0	0	0	0	0	0	0	0	3,243	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	23	0	0	0	0	0	0	0	0	23	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,008	0	0	0	0	0	0	0	0	1,008	5
6	Maintenance	0	0	13,570	0	0	0	0	0	0	0	0	13,570	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	17,844	0	0	0	0	0	0	0	0	17,844	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(11,612)	199	0	0	0	0	0	0	0	0	(11,413)	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	799	0	0	0	0	0	0	0	0	799	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	(11,612)	998	0	0	0	0	0	0	0	0	(10,614)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,533)	(157,531)	12,434	0	0	0	0	0	0	0	0	(154,630)	19
20	Fees, Subscriptions & Promotions	(30,470)	0	6,190	0	0	0	0	0	0	0	0	(24,280)	20
21	Clerical & General Office Expenses	0	0	189,392	0	0	0	0	0	0	0	0	189,392	21
22	Employee Benefits & Payroll Taxes	0	0	25,560	0	0	0	0	0	0	0	0	25,560	22
23	Inservice Training & Education	0	0	783	0	0	0	0	0	0	0	0	783	23
24	Travel and Seminar	(5,849)	0	4,046	0	0	0	0	0	0	0	0	(1,803)	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	10,722	0	0	0	0	0	0	0	0	10,722	26
27	Other (specify):*	4,392	0	0	0	0	0	0	0	0	0	0	4,392	27
28	TOTAL General Administration	(41,460)	(157,531)	249,127	0	0	0	0	0	0	0	0	50,136	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(41,460)	(169,143)	267,969	0	0	0	0	0	0	0	0	57,366	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Walnut # 0053405 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	54,781	0	17,634	0	0	0	0	0	0	0	72,415	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46)	49,931	0	189	0	0	0	0	0	0	0	50,074	32
33	Real Estate Taxes	0	34,043	0	0	0	0	0	0	0	0	0	34,043	33
34	Rent-Facility & Grounds	0	(271,560)	0	3,830	0	0	0	0	0	0	0	(267,730)	34
35	Rent-Equipment & Vehicles	0	0	0	5,773	0	0	0	0	0	0	0	5,773	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(46)	(132,805)	0	27,426	0	0	0	0	0	0	0	(105,425)	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	(41,915)	0	0	0	0	0	0	0	0	0	(41,915)	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	(41,915)	0	0	0	0	0	0	0	0	0	(41,915)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,506)	(343,863)	267,969	27,426	0	0	0	0	0	0	0	(89,974)	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	0.00%	\$ (11,612)	\$ (11,612)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(41,915)	(41,915)	3
4	V	19	Adjustment for Related Organization	157,531	Heritage Operations Group, LLC	0.00%		(157,531)	4
5	V								5
6	V	34	Adjustment for Related Organization	271,560	Heritage Manor Real Estate, LLC	0.00%		(271,560)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		34,043	34,043	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		48,356	48,356	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		54,781	54,781	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,575	1,575	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 429,091			\$ 85,228	\$ * (343,863)	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 Operations Group LLC		\$	\$ 3,243	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					23	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,008	19
20	V	6	Maintenance					13,570	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					199	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					799	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					12,434	31
32	V	20	Fees, Subscription, Promotions					6,190	32
33	V	21	Clerical & General Office Expenses					189,392	33
34	V	22	Employee Benefits & Payroll Taxes					25,560	34
35	V	23	Inservice Training & Education					783	35
36	V	24	Travel and Seminar					4,046	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					10,722	38
39	Total			\$			\$ 0	\$ * 267,969	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 LLC		\$	0	15
16	V	30	Depreciation					17,634	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					189	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					3,830	20
21	V	35	Rent-Equipment & Vehicles					5,773	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	\$ * 27,426	39

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

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 Health Walnut# 0053405

Report Period Beginning:

01/01/16Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	62	\$ 3,243	1
2	2	Food Purchase	Beds	2,571	26	0	0	62	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	62	23	3
4	4	Laundry	Beds	2,571	26	0	0	62	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	62	1,008	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	62	13,570	6
7	7	Other	Beds	2,571	26	0	0	62	0	7
8	9	Medical Director	Beds	2,571	26	0	0	62	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	62	199	9
10	11	Activities	Beds	2,571	26	0	0	62	0	10
11	12	Social Service	Beds	2,571	26	0	0	62	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	62	799	12
13	14	Program Transportation	Beds	2,571	26	0	0	62	0	13
14	15	Other	Beds	2,571	26	0	0	62	0	14
15	17	Administrative	Beds	2,571	26	0	0	62	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	62	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	62	12,434	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	62	6,190	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	62	189,392	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	62	25,560	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	62	783	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	62	4,046	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	62	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	62	10,722	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 267,969	25

Facility Name & ID Number Heritage Health Walnut # 0053405 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ 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	2,571	26	\$	\$	62	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		62	17,634	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			62		3
4	32	Interest	Beds	2,571	26	7,851		62	189	4
5	33	Real Estate Taxes	Beds	2,571	26			62		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		62	3,830	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		62	5,773	7
8	36	Other	Beds	2,571	26			62		8
9	38	Medically Nec Transportation	Beds	2,571	26			62		9
10	39	Ancillary Service Centers	Beds	2,571	26			62		10
11	40	Barber and Beauty Shops	Beds	2,571	26			62		11
12	41	Coffee and Gift Shops	Beds	2,571	26			62		12
13	42	Other	Beds	2,571	26			62		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,137,301	\$		\$ 27,426	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	Morton Community Bank		x	Mortgage			\$				\$ 48,356	1
2	Morton Community Bank		x	Loan Fee Amortization							1,575	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							28,151	6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 78,082	9
	B. Non-Facility Related*											
10	Interest Income										(46)	10
11												11
12	Allocated Corporate										189	12
13												13
14	TOTAL Non-Facility Related						\$				\$ 143	14
15	TOTALS (line 9+line14)						\$				\$ 78,225	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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$34,043	2
3. Under or (over) accrual (line 2 minus line 1).				\$34,043	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$34,043	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	26,663	8	
		2012	34,518	9	
		2013	33,172	10	
		2014	34,356	11	
		2015	34,043	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

FACILITY NAME	Heritage Health Walnut	COUNTY	Bureau
---------------	------------------------	--------	--------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 03-17-100-003		\$ 42,298.98	\$ 33,839.00
2. 03-17-202-001		\$ 255.44	\$ 204.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 42,554.42	\$ 34,043.00

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? x YES NO

C. Tax Bills

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.**

A. Square Feet: 18,000

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.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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).
Walnut Apartments - Independent living units located adjacent to SNF facility. Only combined cost is real estate tax expense.

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				\$ 20,610	1
2					2
3	TOTALS			\$ 20,610	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	62				\$ 469,470	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Improvements		1977		1,605					9
10	Improvements		1979		15					10
11	Improvements		1978		3,737					11
12	Improvements		1980		12,962					12
13	Improvements		1981		6,721					13
14	Improvements		1982		2,572					14
15	Improvements		1983		1,394					15
16	Improvements		1984		10,068					16
17	Improvements		1985		2,599					17
18	Improvements		1988		6,911					18
19	Improvements		1991		15,262					19
20	Improvements		1992		28,595					20
21	Improvements		1993		8,420					21
22	Improvements		1994		12,336					22
23	Improvements		1995		14,430					23
24	Improvements		1996		10,346					24
25	Improvements		1999		17,393					25
26	Wander Guard System		2000		760					26
27	Fire Alarm		2000		675					27
28	Main Entrance Alarm		2000		2,422					28
29	Drapes		2001		1,126					29
30	Fire Doors		2001		2,255					30
31										31
32										32
33	C/O Allocation					17,634		17,634		33
34	Book Depreciation					50,506		50,506		34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Walnut

0053405

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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 Living Room Railing	2001	\$ 444	\$		\$	\$	\$	37
38 Drapes	2001	967						38
39								39
40 Improvements	1973	22,000						40
41 Improvements	1976	1,055						41
42 Improvements	1978	73						42
43 Improvements	1980	48						43
44 Improvements	1982	1,616						44
45 Improvements	1983	1,330						45
46 Improvements	1984	213						46
47 Improvements	1985	11,880						47
48 Improvements	1988	400						48
49 Improvements	1995	8,735						49
50								50
51 Retention Pond	1997	7,565						51
52								52
53 Improvements	1978	53,783						53
54 Improvements	1979	1,207						54
55 Improvements	1982	105						55
56 Improvements	1984	310						56
57 Improvements	1985	1,107						57
58 Improvements	1986	570						58
59 Improvements	1987	1,811						59
60 Improvements	1988	575						60
61 Improvements	1989	3,412						61
62 Improvements	1990	10,184						62
63 Improvements	1991	3,193						63
64 Improvements	1994	11,944						64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 776,601	\$ 68,140		\$ 68,140	\$	\$	70

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

Facility Name & ID Number Heritage Health Walnut

0053405

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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	Totals from Page 12A, Carried Forward		\$ 776,601	\$ 68,140		\$ 68,140	\$	\$	1
2									2
3	Cabinets	1998	3,647						3
4	Bathroom Fixtures	1999	18,379						4
5	Doors	1999	4,900						5
6	Furnace	2001	1,527						6
7	Air Conditioner	2001	1,435						7
8									8
9	Smoke Detector	2002	2,754						9
10	Emergency Lights	2002	1,188						10
11	Fire Dampers	2002	6,455						11
12	Insulated Door	2002	635						12
13									13
14	Heating Ducts	2003	6,455						14
15	Shower Stall	2003	1,410						15
16	Rooftop A/C	2003	7,550						16
17									17
18	Door Monitor	2004	3,528						18
19	3 Keyless Door Locks	2004	1,086						19
20									20
21	Boiler	2005	3,725						21
22	Water Heater	2005	4,700						22
23	Door Frames	2005	1,217						23
24	Fire Ext	2005	1,632						24
25	A/C Condenser	2005	1,850						25
26	MedCare Stand	2005	1,217						26
27									27
28	Foundation repair	2006	2,992						28
29	Valve -- Water Heater	2006	587						29
30	Service sink	2006	912						30
31	Building wiring	2006	6,659						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 863,041	\$ 68,140		\$ 68,140	\$	\$	34

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

Facility Name & ID Number Heritage Health Walnut

0053405

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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	Totals from Page 12B, Carried Forward		\$ 863,041	\$ 68,140		\$ 68,140	\$	\$	1
2									2
3	Furnace	2007	2,851						3
4	HVAC Air handler	2007	7,400						4
5	Downflow a/c coil	2007	3,555						5
6	2 Hanging furnaces	2007	7,458						6
7	Window	2007	1,512						7
8									8
9	Compressor	2008	1,338						9
10	Corridor painting	2008	1,700						10
11	Parking Lot Seal	2008	7,850						11
12	A/C condensor	2008	6,886						12
13	Smoke Damper	2008	2,455						13
14	Laundry Room A/C	2008	6,088						14
15									15
16	Corridor Renovation: Paint, lighting, flooring & Décor	2009	48,271						16
17	Therapy Room Renovation: Paint & Décor	2009	4,100						17
18	Wanderguard	2009	3,250						18
19	West Wing Air Handler	2009	6,265						19
20	Patio Renovation: Concrete	2009	4,219						20
21	Garage Siding	2009	3,634						21
22	Roof	2009	21,328						22
23									23
24	Phone system	2010	3,118						24
25	Sidewalk	2010	3,188						25
26	Fence	2010	3,900						26
27	Tile & Plumbing Kitchen	2010	24,051						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,037,458	\$ 68,140		\$ 68,140	\$	\$	34

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

Facility Name & ID Number Heritage Health Walnut

0053405

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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	Totals from Page 12C, Carried Forward		\$ 1,037,458	\$ 68,140		\$ 68,140	\$	\$	1
2									2
3	Sprinkler System	2011	90,602						3
4	Ceramic Tile	2011	5,868						4
5	Water Heater	2011	7,595						5
6	Fire Alarm	2011	6,875						6
7	A/C for Therapy Room	2011	7,456						7
8	Aquaclean extractor	2011	3,175						8
9	Asphalt Sealer	2011	7,000						9
10									10
11	Water Heater	2012	5,600						11
12	Doors	2012	3,308						12
13	WiFi Equipment/Installation	2012	5,804						13
14	Boiler	2012	9,125						14
15									15
16	HVAC Unit Purchase and Installation	2013	4,241						16
17	Replace and Install 4 Ton A/C Units (2)	2014	6,320						17
18	Replace and Install New Water Heater	2014	7,200						18
19									19
20	Construct new sign depicting new facility name	2015	10,557						20
21	Dining room remodeling - removal of old flooring, asbestos	2015	19,758						21
22	removal, new flooring, painting, new plumbing and new								22
23	light fixtures.								23
24									24
25	Replace laundry room cooling unit	2016	5,671						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,243,613	\$ 68,140		\$ 68,140	\$	\$	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	\$483,927	\$4,275	\$4,275	\$		\$	71
72	Current Year Purchases	9,169						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$493,096	\$4,275	\$4,275	\$		\$	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		2008 Van	2007	\$58,504	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$58,504	\$	\$	\$		\$

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)			\$	1,815,823
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	72,415
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	72,415
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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: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.

		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:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$3,498Description:Televisions and office equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

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	

(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.)

12345678										
	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	\$		\$ 163,413	\$		\$ 163,413	1
2	Licensed Speech and Language Development Therapist		hrs			16,454			16,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			163,786	1,322		165,108	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				299,239		299,239	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					18,378			18,378	13
14	TOTAL			\$		\$ 362,031	\$ 300,561		\$ 662,592	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	\$ 14,786	\$	1
2	Cash-Patient Deposits	4,995		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	687,031		3
4	Supply Inventory (priced at)	6,806		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,268		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(131,625)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 607,261	\$	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)	\$ 607,261	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,785	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,995		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,501		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,268		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	15,224		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 291,773	\$	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)	\$ 291,773	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 315,488	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 607,261	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,029,312	1
2	Restatements (describe):		2
3	Reclassify equity investment balance	(815,200)	3
4	Correct out of balance position at 12-31-15	1,204	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 215,316	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,172	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)	\$ 100,172	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)	\$ 315,488	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Walnut

0053405

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,265,559	1
2	Discounts and Allowances for all Levels	(1,180,363)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,085,196	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,099,986	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,099,986	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,320	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	582,994	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,809	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 607,123	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46	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)	\$ 3,792,351	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	668,078	31
32	Health Care	1,503,623	32
33	General Administration	861,519	33
	B. Capital Expense		
34	Ownership	304,129	34
	C. Ancillary Expense		
35	Special Cost Centers	354,830	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)*	\$ 3,692,179	40
41	Income before Income Taxes (line 30 minus line 40)**	100,172	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 100,172	43

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

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

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

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

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

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	1,803	1,898	\$ 70,810	\$ 37.31	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,325	5,605	159,542	28.46	3
4	Licensed Practical Nurses	11,279	11,873	289,472	24.38	4
5	CNAs & Orderlies	33,847	35,629	462,192	12.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	4,098	4,314	47,451	11.00	10
11	Social Service Workers	1,735	1,826	75,108	41.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,270	16,074	173,219	10.78	15
16	Dishwashers					16
17	Maintenance Workers	3,365	3,542	66,126	18.67	17
18	Housekeepers	4,732	4,981	59,433	11.93	18
19	Laundry	4,949	5,211	51,433	9.87	19
20	Administrator	1,984	2,088	82,080	39.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,006	4,217	102,551	24.32	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)	92,393	97,258	\$ 1,639,417 *	\$ 16.86	34

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		8,388		36
37	Medical Records Consultant		2,835		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,316		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		2,140		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,679		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Heritage Health Walnut

0053405

Report Period Beginning:

01/01/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Dennis Grobe

\$ 82,080

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 82,080

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Heritage Operations Group

Mgt services

\$ 157,531

ADP

Payroll tax processing

1,172

Tango Inc.

ACA compliance

448

McKee Environmental

Inspections

425

Legal adj to Zero

9,533

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 169,109

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 14,067

Unemployment Compensation Insurance

12,251

FICA Taxes

125,415

Employee Health Insurance

102,010

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Benefits

17,304

Central Office Allocation

25,560

TOTAL (agree to Schedule V, line 22, col.8)

\$ 296,607

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

2,290

Health Care Worker Background Check (Indicate # of checks performed)

925

PR

6,634

Dues & Subscriptions

4,185

License & Fees

4,317

Central Office Allocation

6,190

Less: Public Relations Expense

(6,634)

Non-allowable advertising

(2,354)

Yellow page advertising ()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 15,553

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

4,061

26

Seminar Expense

2,715

(1,803)

Entertainment Expense ()

TOTAL (agree to Sch. V, line 24, col. 8)

\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Heritage Health Walnut</u>	STATE OF ILLINOIS # <u>0053405</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. HCCI

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

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

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

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

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ 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. \$ 137,416
 This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,132

(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? _____
 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

[illegible]

Heritage Manor Walnut
HFS ID# 611748311001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>		
Provider Participation Fee - \$1.50	Line 20, Col 3	(34,038)
Provider Assesment Fee - \$6.07	Line 20, Col 3	<u>(103,378)</u>
		<u>(137,416)</u>
Provider Participation Fee	Line 42	<u>137,416</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(299,239)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	<u>(18,378)</u>
		<u>(317,617)</u>
Ancillary Service Centers	Line 39	<u>317,617</u>