

Facility Name & ID Number Heritage Manor Dwight LLC

37853 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,905	10,119	3,077	29,101	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,905	10,119	3,077	29,101	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.66%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 92 and days of care provided 3,077

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor Dwight LLC # 37853 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	229,120	15,231		244,351		244,351	3,620	247,971		1
2	Food Purchase		213,227		213,227		213,227		213,227		2
3	Housekeeping	63,066	34,502		97,568		97,568	5	97,573		3
4	Laundry	74,489	16,781		91,270		91,270	1	91,271		4
5	Heat and Other Utilities			112,730	112,730		112,730	1,393	114,123		5
6	Maintenance	94,830	63,259	70,350	228,439		228,439	21,238	249,677		6
7	Other (specify):*										7
8	TOTAL General Services	461,505	343,000	183,080	987,585		987,585	26,257	1,013,842		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,847,889	174,739	11,197	2,033,825		2,033,825	(23,426)	2,010,399		10
10a	Therapy		683,961	13,258	697,219	(697,219)					10a
11	Activities	119,574	6,042		125,616		125,616		125,616		11
12	Social Services	38,075		3,866	41,941		41,941		41,941		12
13	CNA Training	1,200		273	1,473		1,473	999	2,472		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,006,738	864,742	39,394	2,910,874	(697,219)	2,213,655	(22,427)	2,191,228		16
	C. General Administration										
17	Administrative	81,682			81,682		81,682		81,682		17
18	Directors Fees										18
19	Professional Services			444,252	444,252		444,252	(427,600)	16,652		19
20	Dues, Fees, Subscriptions & Promotions			240,845	240,845	(209,459)	31,386	(7,417)	23,969		20
21	Clerical & General Office Expenses	235,323	22,611	17,021	274,955		274,955	333,604	608,559		21
22	Employee Benefits & Payroll Taxes			502,541	502,541		502,541	45,107	547,648		22
23	Inservice Training & Education			7,413	7,413		7,413	(2,414)	4,999		23
24	Travel and Seminar			11,154	11,154		11,154	(6,155)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			32,565	32,565		32,565	10,882	43,447		26
27	Other (specify):* Lost resident items			68,993	68,993		68,993	(68,400)	593		27
28	TOTAL General Administration	317,005	22,611	1,324,784	1,664,400	(209,459)	1,454,941	(122,393)	1,332,548		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,785,248	1,230,353	1,547,258	5,562,859	(906,678)	4,656,181	(118,563)	4,537,618		29

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

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

Facility Name & ID Number Heritage Manor Dwight LLC

#37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			194,917	194,917		194,917	27,421	222,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,176	47,176		47,176	(134)	47,042			32
33	Real Estate Taxes			44,141	44,141		44,141		44,141			33
34	Rent-Facility & Grounds			210,000	210,000		210,000	5,548	215,548			34
35	Rent-Equipment & Vehicles			18,995	18,995		18,995	7,087	26,082			35
36	Other (specify):*											36
37	TOTAL Ownership			515,229	515,229		515,229	39,922	555,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			616,772	616,772	697,219	1,313,991	(201,328)	1,112,663			39
40	Barber and Beauty Shops			4,729	4,729		4,729		4,729			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					209,459	209,459		209,459			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			621,501	621,501	906,678	1,528,179	(201,328)	1,326,851			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,785,248	1,230,353	2,683,988	6,699,589		6,699,589	(279,969)	6,419,620			45

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

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,729)			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	(3,896)			17
18	Fines and Penalties				18
19	Entertainment	(13,722)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(116,659)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,400)			24
25	Fund Raising, Advertising and Promotional	(14,934)			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)	\$ (219,340)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,629)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (60,629)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (279,969)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Heritage Manor Dwight LLC

ID# 37853

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22		(116,659)	19	22
23				23
24		(68,400)	27	24
25		(14,934)	20	25
26				26
27		0	29	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	(199,993)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Dwight LLC# 37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	3,620	0	0	0	0	0	0	0	0	3,620	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	5	0	0	0	0	0	0	0	0	5	3
4	Laundry	0	0	1	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	0	1,393	0	0	0	0	0	0	0	0	1,393	5
6	Maintenance	0	0	21,238	0	0	0	0	0	0	0	0	21,238	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	26,257	0	0	0	0	0	0	0	0	26,257	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	(23,767)	341	0	0	0	0	0	0	0	0	(23,426)	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	999	0	0	0	0	0	0	0	0	999	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	(23,767)	1,340	0	0	0	0	0	0	0	0	(22,427)	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	(116,659)	(326,296)	15,355	0	0	0	0	0	0	0	0	(427,600)	19
20	Fees, Subscriptions & Promotions	(14,934)	0	7,517	0	0	0	0	0	0	0	0	(7,417)	20
21	Clerical & General Office Expenses	0	0	333,604	0	0	0	0	0	0	0	0	333,604	21
22	Employee Benefits & Payroll Taxes	0	0	45,107	0	0	0	0	0	0	0	0	45,107	22
23	Inservice Training & Education	(3,896)	(68)	1,550	0	0	0	0	0	0	0	0	(2,414)	23
24	Travel and Seminar	(13,722)	0	7,567	0	0	0	0	0	0	0	0	(6,155)	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	10,882	0	0	0	0	0	0	0	0	10,882	26
27	Other (specify):*	(68,400)	0	0	0	0	0	0	0	0	0	0	(68,400)	27
28	TOTAL General Administration	(217,611)	(326,364)	421,582	0	0	0	0	0	0	0	0	(122,393)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,611)	(350,131)	449,179	0	0	0	0	0	0	0	0	(118,563)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Dwight LLC # 37853 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	27,421	0	0	0	0	0	0	0	27,421	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,729)	0	0	1,595	0	0	0	0	0	0	0	(134)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,548	0	0	0	0	0	0	0	5,548	34
35	Rent-Equipment & Vehicles	0	0	0	7,087	0	0	0	0	0	0	0	7,087	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,729)	0	0	41,651	0	0	0	0	0	0	0	39,922	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	(201,328)	0	0	0	0	0	0	0	0	0	(201,328)	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	(201,328)	0	0	0	0	0	0	0	0	0	(201,328)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(219,340)	(551,459)	449,179	41,651	0	0	0	0	0	0	0	(279,969)	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		\$(23,767)	\$(23,767)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(68)	(68)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(201,328)	(201,328)	3
4	V	19 Adjustment for Related Organization	326,296	Heritage Operations Group, LLC			(326,296)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 326,296			\$(225,163)	\$ * (551,459)	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		\$	\$ 3,620	15
16	V	2 Food Purchase					0	16
17	V	3 Housekeeping					5	17
18	V	4 Laundry					1	18
19	V	5 Heat & Other Utilities					1,393	19
20	V	6 Maintenance					21,238	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					341	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					999	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					15,355	31
32	V	20 Fees, Subscription, Promotions					7,517	32
33	V	21 Clerical & General Office Expenses					333,604	33
34	V	22 Employee Benefits & Payroll Taxes					45,107	34
35	V	23 Inservice Training & Education					1,550	35
36	V	24 Travel and Seminar					7,567	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					10,882	38
39	Total		\$			\$	0	\$ * 449,179 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Operations Group		\$	\$	0 15
16	V	30 Depreciation						27,421 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						1,595 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						5,548 20
21	V	35 Rent-Equipment & Vehicles						7,087 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							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	\$	0 \$ * 41,651 39

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

Facility Name & ID Number Heritage Manor Dwight LLC # 37853 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Heritage Enterprises Inc.	Sole Member		100.00					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,578	26	\$ 101,433	\$ 109,431	92	\$ 3,620	1
2	2	Food Purchase	Beds	2,578	26	0	0	92	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	92	5	3
4	4	Laundry	Beds	2,578	26	16	0	92	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	92	1,393	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	92	21,238	6
7	7	Other	Beds	2,578	26	0	0	92	0	7
8	9	Medical Director	Beds	2,578	26	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	92	341	9
10	11	Activities	Beds	2,578	26	0	0	92	0	10
11	12	Social Service	Beds	2,578	26	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	92	999	12
13	14	Program Transportation	Beds	2,578	26	0	0	92	0	13
14	15	Other	Beds	2,578	26	0	0	92	0	14
15	17	Administrative	Beds	2,578	26	0	0	92	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	92	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	92	15,355	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	92	7,517	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	92	333,604	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	92	45,107	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	92	1,550	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	92	7,567	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	92	10,882	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 449,179	25

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,578	26	\$	92	\$	1
2	30	Depreciation	Beds	2,578	26	768,393	92	27,421	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		92		3
4	32	Interest	Beds	2,578	26	44,696	92	1,595	4
5	33	Real Estate Taxes	Beds	2,578	26		92		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	92	5,548	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	92	7,087	7
8	36	Other	Beds	2,578	26		92		8
9	38	Medically Nec Transportation	Beds	2,578	26		92		9
10	39	Ancillary Service Centers	Beds	2,578	26		92		10
11	40	Barber and Beauty Shops	Beds	2,578	26		92		11
12	41	Coffee and Gift Shops	Beds	2,578	26		92		12
13	42	Other	Beds	2,578	26		92		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,167,144	\$	\$ 41,651	25

Facility Name & ID Number

Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Bank of America		x	Working Capital						47,176										
7																				
8																				
9	TOTAL Facility Related									47,176										
B. Non-Facility Related*																				
10	Interest Income									(1,729)										
11																				
12	Allocated Corporate									1,595										
13																				
14	TOTAL Non-Facility Related									(134)										
15	TOTALS (line 9+line14)									47,042										

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.)

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Dwight LLC COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 37853

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>050504483019</u>	_____	\$ <u>45,690.34</u>	\$ <u>45,690.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>45,690.34</u></u>	\$ <u><u>45,690.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

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	92			\$	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	1992 Improvements	1992		8,456					9
10	1993 Improvements	1993		586,243					10
11	1994 Improvements	1994		12,874					11
12	1995 Improvements	1995		496					12
13	Water Heater	1996		7,350					13
14	Interior Rehab (see attached)	1997		118,804					14
15	Garbage Disposal	1997		983					15
16									16
17	Parking Lot	1998		2,717					17
18	Interior Rehab	1998		17,242					18
19									19
20	Alarm Repair/Replacement	1999		1,120					20
21	Air Conditioning Unit	1999		2,461					21
22	Shower Room Repair	1999		6,345					22
23									23
24	Fire Dampers	2000		1,290					24
25	Boiler	2000		1,540					25
26									26
27	Water Heater	2001		7,200					27
28	Window Replacements	2001		4,437					28
29	Flooring -- Kitchen	2001		604					29
30	Code Alert System	2001		933					30
31	Motor Reolacement--A/C	2001		1,398					31
32									32
33	C/O Allocation				27,421		27,421		33
34	Book Depreciation				136,428		136,428		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 Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	A/C compressor	2002	\$ 582	\$		\$	\$	\$	37
38	Boiler Tubing	2002	11,208						38
39	Backflow preventor	2002	2,803						39
40	Wallcoverings	2002	21,813						40
41	Compressor	2002	1,175						41
42	Rooftop A/C unit	2002	20,169						42
43	adustment	2002	(9,766)						43
44	Wallcoverings	2003	1,528						44
45	Rooftop A/C unit	2003							45
46	Exterior Doors	2003	3,121						46
47	30 Gallon Tank	2003	1,056						47
48	Compressor	2003	1,839						48
49	Walk in Freezer	2003	3,301						49
50	Disposal	2003	771						50
51									51
52	Fire Supression System	2004	1,523						52
53	Pump	2004	714						53
54	Boiler	2004	13,085						54
55	Water Softener	2004	1,467						55
56	Parking Lot Sealant	2004	2,800						56
57	Laundry drain	2004	2,350						57
58									58
59	Motor --Circulator	2005	1,674						59
60	Water Heater	2005	10,113						60
61	Kitchen Door	2005	240						61
62	A/C compressor	2005	175						62
63	Generator Panel	2005	833						63
64	Closet Rehab	2005	1,137						64
65	Exterior Lights	2005	127						65
66		2005	4,597						66
67		2005	1,059						67
68		2005	7,450						68
69		2005	1,967						69
70	TOTAL (lines 4 thru 69)		\$ 893,404	\$ 163,849		\$ 163,849	\$	\$	70

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

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 893,404	\$ 163,849		\$ 163,849	\$	\$	1
2	Inline exhaust	2006	2,465						2
3	A/C compressor	2006	8,093						3
4	Exhaust fan	2006	2,435						4
5	Roof	2006	97,870						5
6	Dayroom -- paint	2006							6
7	Sewer	2006	2,260						7
8									8
9	Dayroom -- paint	2007	10,633						9
10	In-sink Erator	2007	895						10
11	Roof A/C	2007	12,269						11
12	Window	2007	583						12
13	Water Softener	2007	17,709						13
14	Water Heater	2007	11,668						14
15	Exterior Painting	2007	14,215						15
16	Water Heater	2007	12,140						16
17	adjustments	2007	(3,034)						17
18	Boiler	2008	6,030						18
19	Kitchen/Restroom Upgrade	2008	3,989						19
20	HVAC Unit	2008	13,845						20
21	Resident Room/Corridor Painting	2008	4,275						21
22									22
23	Shower	2009	33,402						23
24	Sidewalk	2009	3,860						24
25	Dining room rehab: flooring, wallcovering & labor	2009	16,336						25
26	Nurse Call system	2009	257,238						26
27									27
28									28
29	Fire Alarm	2010	47,091						29
30	Storage Shed/garage	2010	40,207						30
31	Asphalt Drive/parking lot		35,536						31
32	Facility Remodel		813,560						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,358,974	\$ 163,849		\$ 163,849	\$	\$	34

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

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,358,974	\$ 163,849		\$ 163,849	\$	\$	1
2									2
3	Landscaping	2011	17,207						3
4	Facility Remodel	2011	99,642						4
5	Rooftop A/C	2011	16,547						5
6									6
7	Water heater	2012	13,186						7
8	Compressor	2012	6,742						8
9	Lighting Upgrade	2012	2,762						9
10									10
11	Rooftop A/C Units	2013	15,027						11
12									12
13	Rooftop AC Unit	2014	8,608						13
14	Install New Generator	2014	79,653						14
15	Roof Replacement-Partial	2014	23,796						15
16	Replace Water Heater	2014	13,400						16
17									17
18	Rooftop unit replacement - add Lennox; remove Trane	2015	12,936						18
19	Install amp disconnect to generator	2015	2,870						19
20	Replacement of condensor in mult zone compressor unit	2015	6,310						20
21	Purchase and installation of new dishwasher	2015	13,273						21
22	Upgrade of HVAC controls	2015	24,430						22
23									23
24	Replaced Carrier Unit compressor	2016	6,523						24
25									25
26	Replaced original boiler	2017	180,571						26
27	Replaced condensor coil	2017	14,036						27
28	Added emergency power to critical panel	2017	4,626						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,921,119	\$ 163,849		\$ 163,849	\$	\$	34

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

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 925,435	\$ 58,489	\$ 58,489	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 925,435	\$ 58,489	\$ 58,489	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2009 Turtletop bus	2008	\$ 61,091	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,091	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,907,645	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 222,338	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Dwight Continental Manor.

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:		92		\$ 210,000	5	15	3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 210,000			7

10. Effective dates of current rental agreement:

Beginning 3/2014

Ending 3/2019

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

Fiscal Year Ending Annual Rent

12.	<u>/2018</u>	\$ <u>210,000</u>
13.	<u>/2019</u>	\$ <u>210,000</u>
14.		\$

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 18,995 Description: Televisions

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		273		273
3	Classroom Wages (a)		1,200		1,200
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,473	\$	\$ 1,473
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,473		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 334,315	\$		\$ 334,315	1
2	Licensed Speech and Language Development Therapist		hrs			39,068			39,068	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			243,389	0		243,389	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				683,961		683,961	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					13,258			13,258	13
14	TOTAL			\$		\$ 630,030	\$ 683,961		\$ 1,313,991	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 896	\$	1
2	Cash-Patient Deposits	17,187		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	890,838		3
4	Supply Inventory (priced at <u>FIFO</u>)	24,899		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,784		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,189,007)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (253,403)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,969,524		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	986,526		16
17	Accumulated Depreciation (book methods)	(2,733,319)		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)	\$ 1,222,731	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 969,328	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,382	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,187		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,921		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,964		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,975		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	25,834		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 435,263	\$	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)	\$ 435,263	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 534,065	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 969,328	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 478,508	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 478,508	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	55,557	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)	\$ 55,557	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)	\$ 534,065	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,032,621	1
2	Discounts and Allowances for all Levels	(2,273,816)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,758,805	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,666,992	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,666,992	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	6,056	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,294,397	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	24,589	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,325,042	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,729	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,729	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund income	2,578	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,578	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,755,146	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	987,585	31
32	Health Care	2,910,874	32
33	General Administration	1,664,400	33
B. Capital Expense			
34	Ownership	515,229	34
C. Ancillary Expense			
35	Special Cost Centers	621,501	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)*	\$ 6,699,589	40
41	Income before Income Taxes (line 30 minus line 40)**	55,557	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,557	43

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

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

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

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

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

Facility Name & ID Number Heritage Manor Dwight LLC

37853

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,763	1,856	\$ 64,941	\$ 34.99	1
2	Assistant Director of Nursing	1,869	1,968	60,335	30.66	2
3	Registered Nurses	20,245	21,311	644,933	30.26	3
4	Licensed Practical Nurses	3,024	3,183	75,959	23.86	4
5	CNAs & Orderlies	58,082	61,139	881,735	14.42	5
6	CNA Trainees	137	144	1,200	8.33	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,124	5,394	119,986	22.24	8
9	Activity Director					9
10	Activity Assistants	8,119	8,546	119,574	13.99	10
11	Social Service Workers	1,709	1,799	38,075	21.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,039	21,094	229,120	10.86	15
16	Dishwashers					16
17	Maintenance Workers	4,606	4,848	94,830	19.56	17
18	Housekeepers	6,484	6,825	63,066	9.24	18
19	Laundry	6,661	7,011	74,489	10.62	19
20	Administrator	1,801	1,896	81,682	43.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,078	10,608	235,323	22.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,741	157,622	\$ 2,785,248 *	\$ 17.67	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	10,800		36
37	Medical Records Consultant	1,814		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,274		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,866		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,754		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

Facility Name & ID Number Heritage Manor Dwight LLC# 37853Report Period Beginning: 1/1/2017Ending: 12/31/2017**XX. GENERAL INFORMATION:**

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 209,459
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 242
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor -Dwight
IDPH ID# 37853
HFS Cost Report - December 31, 2017
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	683,961
Purchased Hospital Services		3,287
Purchased Laboratory Services		6,543
Purchased Radiology Services		<u>3,428</u>
Amount Reclassified to Line 39	\$	<u><u>697,219</u></u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	50,370
Provider Assessment Fee - \$6.70		<u>159,089</u>
Amount Reclassified to Line 42		<u><u>209,459</u></u>