

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

<p>I. IDPH License ID Number: <u>48918</u></p> <p>Facility Name: <u>Heritage Manor Jacksonville LLC</u></p> <p>Address: <u>873 Grove Street</u> <u>Jacksonville</u> <u>62650</u> <small>Number City Zip Code</small></p> <p>County: <u>Morgan</u></p> <p>Telephone Number: <u>217-479-3400</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2007</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David M Underwood</u> Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP/CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # () </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP/CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP/CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()							

Facility Name & ID Number Heritage Manor Jacksonville LLC

48918 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	175	Skilled (SNF)	175	63,875	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,395	5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,270	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	23,988	18,049	4,926	46,963	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	1,057	1,575	0	2,632	12
13	DD 16 OR LESS					13
14	TOTALS	25,045	19,624	4,926	49,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.62%

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 7/2007

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 175 and days of care provided 4,926

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 Jacksonville LLC # 48918 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	495,605	19,034		514,639		514,639	7,790	522,429		1
2	Food Purchase		361,277		361,277		361,277		361,277		2
3	Housekeeping	252,952	36,548		289,500		289,500	11	289,511		3
4	Laundry	93,449	18,004		111,453		111,453	1	111,454		4
5	Heat and Other Utilities			241,361	241,361		241,361	2,997	244,358		5
6	Maintenance	146,964	147,342	132,959	427,265		427,265	45,709	472,974		6
7	Other (specify):*										7
8	TOTAL General Services	988,970	582,205	374,320	1,945,495		1,945,495	56,508	2,002,003		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	3,354,354	238,996	218,268	3,811,618		3,811,618	(27,350)	3,784,268		10
10a	Therapy		937,768	29,686	967,454	(967,421)	33		33		10a
11	Activities	147,057	3,647		150,704		150,704		150,704		11
12	Social Services	87,629		5,382	93,011		93,011		93,011		12
13	CNA Training							2,150	2,150		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,589,040	1,180,411	271,336	5,040,787	(967,421)	4,073,366	(25,200)	4,048,166		16
	C. General Administration										
17	Administrative	105,092			105,092		105,092		105,092		17
18	Directors Fees										18
19	Professional Services			594,747	594,747		594,747	(555,337)	39,410		19
20	Dues, Fees, Subscriptions & Promotions			406,083	406,083	(358,960)	47,123	(4,823)	42,300		20
21	Clerical & General Office Expenses	363,800	31,755	37,346	432,901		432,901	717,974	1,150,875		21
22	Employee Benefits & Payroll Taxes			913,937	913,937		913,937	97,078	1,011,015		22
23	Inservice Training & Education			8,813	8,813		8,813	(3,814)	4,999		23
24	Travel and Seminar			3,247	3,247		3,247	1,752	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,287	78,287		78,287	23,419	101,706		26
27	Other (specify):* Lost resident items			6,311	6,311		6,311	(6,000)	311		27
28	TOTAL General Administration	468,892	31,755	2,048,771	2,549,418	(358,960)	2,190,458	270,249	2,460,707		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,046,902	1,794,371	2,694,427	9,535,700	(1,326,381)	8,209,319	301,557	8,510,876		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 Jacksonville LLC

#48918

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							372,346	372,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,735	89,735		89,735	108,484	198,219			32
33	Real Estate Taxes							91,521	91,521			33
34	Rent-Facility & Grounds			1,038,060	1,038,060		1,038,060	(1,026,121)	11,939			34
35	Rent-Equipment & Vehicles			41,773	41,773		41,773	15,253	57,026			35
36	Other (specify):*											36
37	TOTAL Ownership			1,169,568	1,169,568		1,169,568	(438,517)	731,051			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,840,998	1,840,998	967,421	2,808,419	(245,124)	2,563,295			39
40	Barber and Beauty Shops		591	22,407	22,998		22,998		22,998			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					358,960	358,960		358,960			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		591	1,863,405	1,863,996	1,326,381	3,190,377	(245,124)	2,945,253			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,046,902	1,794,962	5,727,400	12,569,264		12,569,264	(382,084)	12,187,180			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,217)			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	(7,048)			17
18	Fines and Penalties				18
19	Entertainment	(14,534)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,131)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(21,000)			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)	\$ (51,930)		\$	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)	(330,154)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (330,154)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (382,084)		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 Jacksonville LLC

ID# 48918

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		(2,131)	19	22
23				23
24		(6,000)	27	24
25		(21,000)	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	(29,131)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Jacksonville LLC# 48918

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	7,790	0	0	0	0	0	0	0	0	7,790	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	11	0	0	0	0	0	0	0	0	11	3
4	Laundry	0	0	1	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	0	2,997	0	0	0	0	0	0	0	0	2,997	5
6	Maintenance	0	0	45,709	0	0	0	0	0	0	0	0	45,709	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	56,508	0	0	0	0	0	0	0	0	56,508	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	(28,083)	733	0	0	0	0	0	0	0	0	(27,350)	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	2,150	0	0	0	0	0	0	0	0	2,150	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	(28,083)	2,883	0	0	0	0	0	0	0	0	(25,200)	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	(2,131)	(586,253)	33,047	0	0	0	0	0	0	0	0	(555,337)	19
20	Fees, Subscriptions & Promotions	(21,000)	0	16,177	0	0	0	0	0	0	0	0	(4,823)	20
21	Clerical & General Office Expenses	0	0	717,974	0	0	0	0	0	0	0	0	717,974	21
22	Employee Benefits & Payroll Taxes	0	0	97,078	0	0	0	0	0	0	0	0	97,078	22
23	Inservice Training & Education	(7,048)	(102)	3,336	0	0	0	0	0	0	0	0	(3,814)	23
24	Travel and Seminar	(14,534)	0	16,286	0	0	0	0	0	0	0	0	1,752	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	23,419	0	0	0	0	0	0	0	0	23,419	26
27	Other (specify):*	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	27
28	TOTAL General Administration	(50,713)	(586,355)	907,317	0	0	0	0	0	0	0	0	270,249	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,713)	(614,438)	966,708	0	0	0	0	0	0	0	0	301,557	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Jacksonville LLC # 48918 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	0	313,331	0	59,015	0	0	0	0	0	0	0	372,346	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,217)	106,268	0	3,433	0	0	0	0	0	0	0	108,484	32
33	Real Estate Taxes	0	91,521	0	0	0	0	0	0	0	0	0	91,521	33
34	Rent-Facility & Grounds	0	(1,038,060)	0	11,939	0	0	0	0	0	0	0	(1,026,121)	34
35	Rent-Equipment & Vehicles	0	0	0	15,253	0	0	0	0	0	0	0	15,253	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,217)	(526,940)	0	89,640	0	0	0	0	0	0	0	(438,517)	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	(245,124)	0	0	0	0	0	0	0	0	0	(245,124)	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	(245,124)	0	0	0	0	0	0	0	0	0	(245,124)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,930)	(1,386,502)	966,708	89,640	0	0	0	0	0	0	0	(382,084)	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		\$ (28,083)	\$	(28,083)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(102)		(102)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(245,124)		(245,124)	3
4	V	19 Adjustment for Related Organization	586,253	Heritage Operations Group, LLC				(586,253)	4
5	V								5
6	V	34 Adjustment for Related Organization	1,038,060	Heritage Manor Real Estate, LLC				(1,038,060)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		91,521		91,521	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		96,422		96,422	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		313,331		313,331	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		9,846		9,846	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,624,313			\$ 237,811	\$ *	(1,386,502)	14

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

Facility Name & ID Number Heritage Manor Jacksonville LLC# 48918Report Period Beginning: 1/1/2017Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Operations Group		\$	\$ 7,790	15
16	V	2 Food Purchase					0	16
17	V	3 Housekeeping					11	17
18	V	4 Laundry					1	18
19	V	5 Heat & Other Utilities					2,997	19
20	V	6 Maintenance					45,709	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					733	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					2,150	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					33,047	31
32	V	20 Fees, Subscription, Promotions					16,177	32
33	V	21 Clerical & General Office Expenses					717,974	33
34	V	22 Employee Benefits & Payroll Taxes					97,078	34
35	V	23 Inservice Training & Education					3,336	35
36	V	24 Travel and Seminar					16,286	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					23,419	38
39	Total		\$			\$	0	\$ * 966,708 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						59,015 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						3,433 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						11,939 20
21	V	35 Rent-Equipment & Vehicles						15,253 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	\$ * 89,640 39

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

Facility Name & ID Number Heritage Manor Jacksonville LLC # 48918 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 Jacksonville LLC

48918

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	198	\$ 7,790	1
2	2	Food Purchase	Beds	2,578	26	0	0	198	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	198	11	3
4	4	Laundry	Beds	2,578	26	16	0	198	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	198	2,997	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	198	45,709	6
7	7	Other	Beds	2,578	26	0	0	198	0	7
8	9	Medical Director	Beds	2,578	26	0	0	198	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	198	733	9
10	11	Activities	Beds	2,578	26	0	0	198	0	10
11	12	Social Service	Beds	2,578	26	0	0	198	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	198	2,150	12
13	14	Program Transportation	Beds	2,578	26	0	0	198	0	13
14	15	Other	Beds	2,578	26	0	0	198	0	14
15	17	Administrative	Beds	2,578	26	0	0	198	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	198	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	198	33,047	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	198	16,177	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	198	717,974	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	198	97,078	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	198	3,336	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	198	16,286	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	198	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	198	23,419	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 966,708	25

Facility Name & ID Number Heritage Manor Jacksonville LLC

48918

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	\$	198	\$	1
2	30	Depreciation	Beds	2,578	26	768,393	198	59,015	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		198		3
4	32	Interest	Beds	2,578	26	44,696	198	3,433	4
5	33	Real Estate Taxes	Beds	2,578	26		198		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	198	11,939	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	198	15,253	7
8	36	Other	Beds	2,578	26		198		8
9	38	Medically Nec Transportation	Beds	2,578	26		198		9
10	39	Ancillary Service Centers	Beds	2,578	26		198		10
11	40	Barber and Beauty Shops	Beds	2,578	26		198		11
12	41	Coffee and Gift Shops	Beds	2,578	26		198		12
13	42	Other	Beds	2,578	26		198		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	\$	\$ 89,640	25

Facility Name & ID Number

Heritage Manor Jacksonville LLC

48918

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	Bank of America		x	Mortgage			\$	\$		\$ 96,422	1									
2	Bank of America		x	Loan Fee Amortization						9,846	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						89,735	6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 196,003	9									
B. Non-Facility Related*																				
10	Interest Income									(1,217)	10									
11											11									
12	Allocated Corporate									3,433	12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$ 2,216	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 198,219	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	91,521	2
3. Under or (over) accrual (line 2 minus line 1).		\$	91,521	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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.		\$	91,521	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	90,561	8
	2013	93,709	9
	2014	96,706	10
	2015	90,407	11
	2016	91,521	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Jacksonville LLC COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 48918

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>0920308003</u>	_____	\$ <u>120,422.34</u>	\$ <u>91,521.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>120,422.34</u></u>	\$ <u><u>91,521.00</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 Jacksonville LLC

48918

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

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).

Apartments/cottages located on adjacent property but included on the same tax bill.

Allocation has been made and is shown in a separate schedule to this report.

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 an unlabeled column. Row 1: 1, Use, Square Feet, 2005, \$ 100,000, 1. Row 2: 2, Use, Square Feet, Year Acquired, Cost, 2. Row 3: 3, TOTALS, Square Feet, Year Acquired, \$ 100,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	198			\$ 3,295,725	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Facility Sign		2005	1,050					
10	Dietary cabinets		2005	5,864					
11	Ansul system		2005	1,600					
12	Heat detectors		2005	1,777					
13	Door system		2005	17,554					
14	A/C units		2005	10,456					
15									
16	Computer wiring		2005	1,280					
17	A/C compressor		2005	2,849					
18	Shelter care remodel-- paint, flooring, wallpaper		2006	225,040					
19	landscapping		2006	2,262					
20	Boiler		2006	2,580					
21	Heat/cool units		2006	9,517					
22	Fire alarm		2006	2,097					
23	Roof		2006	145,352					
24	Door system		2006	414					
25	Mixing Valve		2006	5,060					
26	Hutton Hall remodel (Shelter Care) -- Window treatments, painting		2006	31,147					
27	sump pump		2006	2,001					
28	2006 audit adjustment		2006	(78,685)					
29									
30									
31									
32									
33	C/O Allocation				59,015		59,015		
34	Book Depreciation				261,526		261,526		
35									
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 Jacksonville LLC

48918

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	Backflow preventer	2007	\$ 3,501	\$		\$	\$	\$	37
38	Shower/faucet	2007	875						38
39	Air Handler	2007	5,215						39
40	HVAC	2007	20,152						40
41	Tree removal	2007	9,491						41
42	Valance	2007	581						42
43	Younkin corridor remodel -- paint	2007	16,420						43
44	Trane compressor	2007	2,841						44
45	Elevator	2007	68,750						45
46	Parking lot	2007	10,570						46
47	Aufit Adjustment	2007	(38,621)						47
48									48
49									49
50									50
51									51
52	Nurse Call System	2008	286,152						52
53	Mechanical systems	2008	12,996						53
54	Condensing Unit	2008	17,965						54
55	Laundry plumbing	2008	12,671						55
56	Heat / Cool units	2008	24,201						56
57	Fire Panel	2008	7,378						57
58	Water Heater	2008	5,272						58
59	Kitchen Air Handler	2008	26,187						59
60	Condensing Unit	2008	4,069						60
61	Wireless Phone system	2008	41,983						61
62	Cables-nurse call	2008	21,185						62
63	Resident Phones	2008	10,081						63
64	Audit Adjustment	2008	2,254						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,257,109	\$ 320,541		\$ 320,541	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 4,257,109	\$ 320,541		\$ 320,541	\$	\$	1
2	Compressor	2009	2,516						2
3	Condensing Unit	2009	16,946						3
4	Boiler Replacement	2009	10,434						4
5	Roof	2009	8,393						5
6	HVAC units	2009	5,735						6
7	Firewall	2009	6,951						7
8	HVAC units	2009	5,106						8
9	Laundry plumbing	2009	7,351						9
10	Sewer ejector	2009	5,189						10
11	Dinning room paint, flooring & labor	2009	55,148						11
12	Cabling	2009	10,874						12
13	Laundry plumbing	2009	7,015						13
14									14
15	Roof Repair	2010	10,654						15
16	heat/cool units	2010	11,449						16
17	Driveway sealant	2010	3,800						17
18	Wanderguard	2010	3,099						18
19	Furnace	2010	4,095						19
20	Carpet	2010	3,523						20
21	Dinning room paint, flooring & labor	2010	53,752						21
22	Boiler Replacement	2010	25,619						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,514,758	\$ 320,541		\$ 320,541	\$	\$	34

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

Facility Name & ID Number Heritage Manor Jacksonville LLC

48918

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		\$ 4,514,758	\$ 320,541		\$ 320,541	\$	\$	1
2									2
3	Islandaire stystem	2011	8,122						3
4	PTAC units	2011	21,011						4
5	44 windows	2011	73,900						5
6	roof	2011	8,393						6
7	boiler	2011	19,466						7
8	sign	2011	12,169						8
9	Technology system	2011	22,503						9
10	walk-in cooler	2011	9,893						10
11	furnace	2011	7,952						11
12	Sprinkler system	2011	27,872						12
13									13
14	Technology system	2012	6,347						14
15	Physical Therapy room rehab : Paint, floors labor	2012	164,844						15
16	Boiler	2012	4,397						16
17	Compressor	2012	3,299						17
18	Nurse Call System	2012	15,854						18
19	Condensing Unit	2012	8,079						19
20	Flooring	2012	3,818						20
21									21
22	Lighting Retrofit	2013	7,286						22
23	Elevator Floor Replacement	2013	7,682						23
24	Elevator Door Restrictors	2013	16,400						24
25	PTAC units	2013	12,195						25
26	Roof Replacement	2013	53,982						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,030,222	\$ 320,541		\$ 320,541	\$	\$	34

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

Facility Name & ID Number Heritage Manor Jacksonville LLC

48918

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 12C, Carried Forward		\$ 5,030,222	\$ 320,541		\$ 320,541	\$	\$	1
2	Furnace Replacement-Dining Room System	2014	7,036						2
3	Cabling and Electrical - Point of Care Kiosks	2014	10,201						3
4	Install (18) PTAC Units	2014	25,140						4
5	Install New Compressor	2014	7,270						5
6	Replaced Furnace, Condensor, and Humidifier	2014	5,048						6
7	Replaced Water Heater	2014	10,494						7
8	Replace Kitchen Door	2014	3,942						8
9	Install Improvements to (4) Passenger Elevators	2014	26,423						9
10									10
11									11
12	Upgraded 7.5 ton and 10 ton compressors	2015	9,419						12
13	Installed new oil pump on 30 ton comprssor	2015	5,082						13
14	Replaced sewer pipe	2015	2,924						14
15									15
16	Replace control switch panel in kitchen	2016	3,192						16
17	Install (2) new boilers to replace existing Kewanee boiler	2016	16,656						17
18									18
19	Installed (2) mini-split system heating units	2017	4,685						19
20	Replaced alternator and hoses on existing generator	2017	9,394						20
21	Installed new exterior sign w/LED lighting	2017	9,691						21
22	Replaced laundry condensing unit	2017	5,485						22
23	Replace laundry room water heater	2017	6,986						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,199,290	\$ 320,541		\$ 320,541	\$	\$	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	\$ 1,458,904	\$ 45,843	\$ 45,843	\$		\$	71
72	Current Year Purchases	34,402						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,493,306	\$ 45,843	\$ 45,843	\$		\$	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		2014 Dodge Grand Caravan	2014	\$ 41,736	\$ 5,962	\$ 5,962	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 41,736	\$ 5,962	\$ 5,962	\$		\$	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)	\$ 6,834,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 372,346	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 372,346	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 41,773 Description: 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.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 830,046	\$		\$ 830,046	1
2	Licensed Speech and Language Development Therapist		hrs			173,755			173,755	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			837,197	33		837,230	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				937,735		937,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					29,686			29,686	13
14	TOTAL			\$		\$ 1,870,684	\$ 937,768		\$ 2,808,452	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	\$ 1,870	\$	1
2	Cash-Patient Deposits	8,247		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,299,316		3
4	Supply Inventory (priced at FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,853		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,711,301)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,398,015)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,398,015)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 211,592	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,247		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	434,135		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,139		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	42,945		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 767,058	\$	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)	\$ 767,058	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,165,073)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,398,015)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,591,268)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,591,268)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(573,805)	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)	\$ (573,805)	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)	\$ (2,165,073)	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	\$ 9,390,588	1
2	Discounts and Allowances for all Levels	(5,001,544)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,389,044	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,297,160	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,297,160	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	1,529	12
13	Barber and Beauty Care	30,293	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,812,763	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	50,314	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,894,899	23
D. Non-Operating Revenue			
24	Contributions	413,139	24
25	Interest and Other Investment Income***	1,217	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 414,356	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)	\$ 11,995,459	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,945,495	31
32	Health Care	5,040,787	32
33	General Administration	2,549,418	33
B. Capital Expense			
34	Ownership	1,169,568	34
C. Ancillary Expense			
35	Special Cost Centers	1,863,996	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)*	\$ 12,569,264	40
41	Income before Income Taxes (line 30 minus line 40)**	(573,805)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (573,805)	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 Jacksonville LLC

48918

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	1,772	1,865	\$ 72,530	\$ 38.89	1
2	Assistant Director of Nursing	1,436	1,512	41,341	27.34	2
3	Registered Nurses	18,223	19,182	605,070	31.54	3
4	Licensed Practical Nurses	28,615	30,122	768,492	25.51	4
5	CNAs & Orderlies	110,890	116,727	1,798,495	15.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,482	3,665	68,426	18.67	8
9	Activity Director					9
10	Activity Assistants	9,544	10,047	147,057	14.64	10
11	Social Service Workers	3,598	3,787	87,629	23.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,862	40,907	495,605	12.12	15
16	Dishwashers					16
17	Maintenance Workers	8,979	9,452	146,964	15.55	17
18	Housekeepers	21,654	22,793	252,952	11.10	18
19	Laundry	8,055	8,479	93,449	11.02	19
20	Administrator	1,756	1,848	105,092	56.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,759	16,588	363,800	21.93	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)	272,625	286,974	\$ 5,046,902 *	\$ 17.59	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	18,000		36
37	Medical Records Consultant	1,680		37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,157		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	5,308		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 34,145		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 16,881		50
51	Licensed Practical Nurses	7,542		51
52	Certified Nurse Assistants/Aides	182,942		52
53	TOTAL (lines 50 - 52)	\$ 207,365		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Michael Schneider</u>			\$ <u>105,092</u>	<u>Workers' Compensation Insurance</u>	\$ <u>150,198</u>	<u>IDPH License Fee</u>	\$ <u>10,320</u>	
				<u>Unemployment Compensation Insurance</u>	<u>34,251</u>	<u>Advertising: Employee Recruitment</u>	<u>3,445</u>	
				<u>FICA Taxes</u>	<u>386,088</u>	<u>Health Care Worker Background Check</u> (Indicate # of checks performed _____)	<u>3,445</u>	
				<u>Employee Health Insurance</u>	<u>308,244</u>	<u>Patient Background Checks</u>		
				<u>Employee Meals</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>105,092</u>	<u>Other Benefits</u>	<u>35,156</u>	<u>PR</u>	<u>8,872</u>	
				<u>Central Office Allocation</u>	<u>97,078</u>	<u>Dues & Subscriptions</u>	<u>12,957</u>	
						<u>License & Fees</u>	<u>5,527</u>	
						<u>Central Office Allocation</u>	<u>16,177</u>	
						<u>Less: Public Relations Expense</u>	<u>(8,872)</u>	
						<u>Non-allowable advertising</u>	<u>(6,126)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>1,011,015</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>42,300</u>	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other			Amount	Description	Line #	Amount	Description	Amount
			\$ _____			\$ _____	<u>Out-of-State Travel</u>	\$ _____
			\$ _____			\$ _____		\$ _____
			\$ _____			\$ _____	<u>In-State Travel</u>	<u>2,573</u>
			\$ _____			\$ _____		<u>120</u>
			\$ _____			\$ _____	<u>Seminar Expense</u>	<u>554</u>
			\$ _____			\$ _____		<u>1,752</u>
			\$ _____			\$ _____	<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ _____	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>4,999</u>
C. Professional Services			Amount					
Vendor/Payee	Type		Amount					
<u>Heritage Operations Group</u>	<u>Mgt services</u>		\$ <u>587,103</u>					
<u>ADP</u>	<u>Payroll tax processing</u>		<u>413</u>					
<u>McKee Environmental</u>	<u>Asbestos testing</u>		<u>5,100</u>					
<u>Legal adj to Zero</u>			<u>2,131</u>					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ <u>594,747</u>					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor Jacksonville LLC# 48918

Report Period Beginning:

1/1/2017

Ending:

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. \$ 358,960
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. \$ 2,741
- (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 - Jacksonville
IDPH ID# 48918
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	\$	937,735
Purchased Hospital Services		14,004
Purchased Laboratory Services		6,658
Purchased Radiology Services		<u>9,024</u>
Amount Reclassified to Line 39	\$	<u><u>967,421</u></u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	95,813
Provider Assessment Fee - \$6.70		<u>263,147</u>
Amount Reclassified to Line 42		<u><u>358,960</u></u>