



Facility Name & ID Number Heritage Manor Carlinville LLC

# 48850 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	95	Skilled (SNF)	95	34,675	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	95	TOTALS	95	34,675	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	15,391	11,080	2,315	28,786	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,391	11,080	2,315	28,786	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 83.02%

**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 95 and days of care provided 2,315

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 Carlinville LLC # 48850 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	197,463	10,923		208,386		208,386	3,738	212,124		1
2	Food Purchase		198,546		198,546		198,546		198,546		2
3	Housekeeping	108,365	35,259		143,624		143,624	5	143,629		3
4	Laundry	58,368	12,809		71,177		71,177	1	71,178		4
5	Heat and Other Utilities			117,980	117,980		117,980	1,438	119,418		5
6	Maintenance	68,036	51,912	71,651	191,599		191,599	21,931	213,530		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	432,232	309,449	189,631	931,312		931,312	27,113	958,425		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,563,181	97,987	46,132	1,707,300		1,707,300	(14,540)	1,692,760		10
10a	Therapy		409,192	23,307	432,499	(432,134)	365		365		10a
11	Activities	69,819	1,719		71,538		71,538		71,538		11
12	Social Services	37,022		3,736	40,758		40,758		40,758		12
13	CNA Training			4,961	4,961		4,961	1,031	5,992		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,670,022	508,898	93,136	2,272,056	(432,134)	1,839,922	(13,509)	1,826,413		16
	<b>C. General Administration</b>										
17	Administrative	71,531			71,531		71,531		71,531		17
18	Directors Fees										18
19	Professional Services			291,036	291,036		291,036	(274,460)	16,576		19
20	Dues, Fees, Subscriptions & Promotions			233,300	233,300	(214,804)	18,496	817	19,313		20
21	Clerical & General Office Expenses	137,144	24,555	13,628	175,327		175,327	344,482	519,809		21
22	Employee Benefits & Payroll Taxes			448,920	448,920		448,920	46,578	495,498		22
23	Inservice Training & Education			5,615	5,615		5,615	(616)	4,999		23
24	Travel and Seminar			4,664	4,664		4,664	335	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,418	35,418		35,418	11,237	46,655		26
27	Other (specify):*			25,200	25,200		25,200	(25,200)			27
28	<b>TOTAL General Administration</b>	208,675	24,555	1,057,781	1,291,011	(214,804)	1,076,207	103,173	1,179,380		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,310,929	842,902	1,340,548	4,494,379	(646,938)	3,847,441	116,777	3,964,218		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 &amp; ID Number

Heritage Manor Carlinville LLC

#48850

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							186,633	186,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,713	48,713		48,713	31,357	80,070			32
33	Real Estate Taxes							37,032	37,032			33
34	Rent-Facility & Grounds			473,040	473,040		473,040	(467,296)	5,744			34
35	Rent-Equipment & Vehicles			8,506	8,506		8,506	7,338	15,844			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			530,259	530,259		530,259	(204,936)	325,323			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			637,376	637,376	432,134	1,069,510	(99,827)	969,683			39
40	Barber and Beauty Shops			221	221		221		221			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					214,804	214,804		214,804			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			637,597	637,597	646,938	1,284,535	(99,827)	1,184,708			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,310,929	842,902	2,508,404	5,662,235		5,662,235	(187,986)	5,474,249			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	(173)			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	(2,183)			17
18	Fines and Penalties				18
19	Entertainment	(7,479)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,111)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,200)			24
25	Fund Raising, Advertising and Promotional	(6,945)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (52,091)		\$	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)	(135,895)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (135,895)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (187,986)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Heritage Manor Carlinville LLC

ID# 48850

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		(10,111)	19	22
23				23
24		(25,200)	27	24
25		(6,945)	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	<b>Total</b>	(42,256)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Carlinville LLC# 48850

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	3,738	0	0	0	0	0	0	0	0	3,738	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	1,438	0	0	0	0	0	0	0	0	1,438	5
6	Maintenance	0	0	21,931	0	0	0	0	0	0	0	0	21,931	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>27,113</b>	<b>0</b>	<b>27,113</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(14,892)	352	0	0	0	0	0	0	0	0	(14,540)	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	1,031	0	0	0	0	0	0	0	0	1,031	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(14,892)</b>	<b>1,383</b>	<b>0</b>	<b>(13,509)</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,111)	(280,205)	15,856	0	0	0	0	0	0	0	0	(274,460)	19
20	Fees, Subscriptions & Promotions	(6,945)	0	7,762	0	0	0	0	0	0	0	0	817	20
21	Clerical & General Office Expenses	0	0	344,482	0	0	0	0	0	0	0	0	344,482	21
22	Employee Benefits & Payroll Taxes	0	0	46,578	0	0	0	0	0	0	0	0	46,578	22
23	Inservice Training & Education	(2,183)	(34)	1,601	0	0	0	0	0	0	0	0	(616)	23
24	Travel and Seminar	(7,479)	0	7,814	0	0	0	0	0	0	0	0	335	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	11,237	0	0	0	0	0	0	0	0	11,237	26
27	Other (specify):*	(25,200)	0	0	0	0	0	0	0	0	0	0	(25,200)	27
28	<b>TOTAL General Administration</b>	<b>(51,918)</b>	<b>(280,239)</b>	<b>435,330</b>	<b>0</b>	<b>103,173</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(51,918)</b>	<b>(295,131)</b>	<b>463,826</b>	<b>0</b>	<b>116,777</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Carlinville LLC # 48850 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	158,240	0	28,393	0	0	0	0	0	0	0	186,633	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(173)	29,878	0	1,652	0	0	0	0	0	0	0	31,357	32
33	Real Estate Taxes	0	37,032	0	0	0	0	0	0	0	0	0	37,032	33
34	Rent-Facility & Grounds	0	(473,040)	0	5,744	0	0	0	0	0	0	0	(467,296)	34
35	Rent-Equipment & Vehicles	0	0	0	7,338	0	0	0	0	0	0	0	7,338	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	(173)	(247,890)	0	43,127	0	0	0	0	0	0	0	(204,936)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(99,827)	0	0	0	0	0	0	0	0	0	(99,827)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	(99,827)	0	0	0	0	0	0	0	0	0	(99,827)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(52,091)	(642,848)	463,826	43,127	0	0	0	0	0	0	0	(187,986)	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		\$ (14,892)	\$ (14,892)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(34)	(34)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(99,827)	(99,827)	3
4	V	19 Adjustment for Related Organization	280,205	Heritage Operations Group, LLC			(280,205)	4
5	V							5
6	V	34 Adjustment for Related Organization	473,040	Heritage Manor Real Estate, LLC			(473,040)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		37,032	37,032	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		27,084	27,084	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		158,240	158,240	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,794	2,794	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 753,245			\$ 110,397	\$ * (642,848)	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		\$	\$	3,738 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						1,438 19
20	V	6 Maintenance						21,931 20
21	V	7 Other						0 21
22	V	9 Medical Director						0 22
23	V	10 Nursing & Medical Records						352 23
24	V	11 Activities						0 24
25	V	12 Social Service						0 25
26	V	13 Nurse Aide Training						1,031 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						15,856 31
32	V	20 Fees, Subscription, Promotions						7,762 32
33	V	21 Clerical & General Office Expenses						344,482 33
34	V	22 Employee Benefits & Payroll Taxes						46,578 34
35	V	23 Inservice Training & Education						1,601 35
36	V	24 Travel and Seminar						7,814 36
37	V	25 Other Admin. Staff Transportation						0 37
38	V	26 Insurance-Prop.Liab.Malpract						11,237 38
39	<b>Total</b>		\$			\$	0	\$ * 463,826 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						28,393 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						1,652 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						5,744 20
21	V	35 Rent-Equipment & Vehicles						7,338 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	\$ * 43,127 39

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

Facility Name & ID Number Heritage Manor Carlinville LLC # 48850 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 Carlinville LLC

# 48850

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	95	\$ 3,738	1
2	2	Food Purchase	Beds	2,578	26	0	0	95	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	95	5	3
4	4	Laundry	Beds	2,578	26	16	0	95	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	95	1,438	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	95	21,931	6
7	7	Other	Beds	2,578	26	0	0	95	0	7
8	9	Medical Director	Beds	2,578	26	0	0	95	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	95	352	9
10	11	Activities	Beds	2,578	26	0	0	95	0	10
11	12	Social Service	Beds	2,578	26	0	0	95	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	95	1,031	12
13	14	Program Transportation	Beds	2,578	26	0	0	95	0	13
14	15	Other	Beds	2,578	26	0	0	95	0	14
15	17	Administrative	Beds	2,578	26	0	0	95	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	95	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	95	15,856	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	95	7,762	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	95	344,482	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	95	46,578	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	95	1,601	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	95	7,814	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	95	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	95	11,237	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 463,826	25

Facility Name & ID Number Heritage Manor Carlinville LLC

# 48850

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	2,571	26	\$	95	\$	1
2	30	Depreciation	Beds	2,571	26	768,393	95	28,393	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26		95		3
4	32	Interest	Beds	2,571	26	44,696	95	1,652	4
5	33	Real Estate Taxes	Beds	2,571	26		95		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	155,453	95	5,744	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	198,602	95	7,338	7
8	36	Other	Beds	2,571	26		95		8
9	38	Medically Nec Transportation	Beds	2,571	26		95		9
10	39	Ancillary Service Centers	Beds	2,571	26		95		10
11	40	Barber and Beauty Shops	Beds	2,571	26		95		11
12	41	Coffee and Gift Shops	Beds	2,571	26		95		12
13	42	Other	Beds	2,571	26		95		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	\$	\$ 43,127	25

Facility Name & ID Number

Heritage Manor Carlinville LLC

# 48850

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of America		x	Mortgage			\$	\$		\$ 27,084	1									
2	Bank of America		x	Loan Fee Amortization						2,794	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	Bank of America		x	Working Capital						48,713	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$		\$ 78,591	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(173)	10									
11											11									
12	Allocated Corporate									1,652	12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 1,479	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$ 80,070	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.)





Facility Name & ID Number Heritage Manor Carlinville LLC

# 48850

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 34,320 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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 32,017	1
2					2
3	TOTALS			\$ 32,017	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	95			\$ 3,265,145	\$		\$	\$	4
5									5
6									6
7									7
8									8
<b>Improvement Type**</b>									
9	Heritage Manor Sign		1996	2,176					9
10	Architect Fees		1996	2,387					10
11	Laundry Room Electrical Repair		1996	3,019					11
12									12
13									13
14	Special Care Unit -- Remodel		1997	30,884					14
15									15
16	Remodel-- Alzheimer Wing		1998	78,813					16
17	A/C Unit		1998	950					17
18	Life Safety Improvements		1998	7,351					18
19	Shower Room Remodel		1998	2,811					19
20	Roof Replacement		1998	92,246					20
21									21
22	Door Alarm		1999	2,317					22
23	Smoke Damperer		1999	498					23
24	Water System		1999	8,115					24
25	Interior Painting--Material and Labor		1999	6,892					25
26	Shower Room Remodel		1999	2,453					26
27	Water Heater		1999	4,253					27
28									28
29									29
30									30
31									31
32									32
33	C/O Allocation				28,393		28,393		33
34	Book Depreciation				145,692		145,692		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 Carlinville LLC# 48850

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	Water Softener	2000	\$ 3,802	\$		\$	\$	\$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	10,318						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,638,207	\$ 174,085		\$ 174,085	\$	\$	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,638,207	\$ 174,085		\$ 174,085	\$	\$	1
2	Window Replacement	2005	371						2
3	HVAC	2005	10,165						3
4	Rooftop A/C	2005	8,997						4
5	Water Storage Tank	2005	4,456						5
6	Rooftop Heater	2005	3,425						6
7									7
8	Sidewalk	2006	630						8
9	Parking Lot Sealer	2006	2,385						9
10	Window Replacement	2006	1,638						10
11	Resident room remodel -- paint, wall coverings	2006	3,390						11
12	Smoke detectors	2006	1,644						12
13									13
14	Resident room remodel -- paint, wall coverings	2007	4,207						14
15	Corridor Rehab -- Paint/Wallpaper	2007	22,058						15
16	HVAC	2007	9,819						16
17	Fire Alarm	2007	2,900						17
18	Rosedale Corridor Rehab-- Paint/ Wallpaper	2007	4,041						18
19	Sprinkler System	2007	3,398						19
20									20
21									21
22	Rosedale Resident room Rehab -- Paint/Wallpaper	2007	26,384						22
23	Rooftop A/C	2007	4,417						23
24	Kitchen Repairs	2007	1,550						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,754,082	\$ 174,085		\$ 174,085	\$	\$	34

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

Facility Name & ID Number Heritage Manor Carlinville LLC# 48850

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,754,082	\$ 174,085		\$ 174,085	\$	\$	1
2	PTAC Units	2008	7,980						2
3	Nurse call/Phone System	2008	157,428						3
4	Kitchen Water Heater	2008	2,600						4
5	Rosedale wing room remodel-- paint/flooring	2008	15,673						5
6	Kitchen plumbing	2008	3,130						6
7	Sprinkler	2008	5,972						7
8	Legacy Unit Remodel--paint/flooring	2008	37,068						8
9	Fire Alarm	2008	47,279						9
10									10
11	Sewer Line	2009	6,355						11
12	Therapy Renovation: paint, electrical, flooring	2009	76,398						12
13	Kitchen pipe	2009	2,700						13
14	Shower	2009	5,080						14
15	Door Alarms	2009	42,322						15
16	Nurse call/Phone System	2009	35,992						16
17	Fire Alarm	2009	15,451						17
18									18
19	Concrete Work & Install Curtains -- therapy room	2010	3,904						19
20	PTAC Units	2010	3,530						20
21	Flooring/Installation Shower room floor	2010	20,394						21
22									22
23	Electric Heat/Cool unit	2011	5,500						23
24	500 gallon grease trap	2011	3,300						24
25	Parking Lot seal	2011	9,481						25
26	Kitchen Exhaust hood	2011	5,500						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,267,119	\$ 174,085		\$ 174,085	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,267,119	\$ 174,085		\$ 174,085	\$	\$	1
2									2
3	Kitchen Rehab - Flooring	2013	19,580						3
4	Lighting Retrofit	2013	7,269						4
5	A/C Units	2013	2,592						5
6	Walk in Cooler- Freezer	2013	25,216						6
7	Install Dry Sidewalls in Therapy	2013	3,200						7
8									8
9	Walk in Cooler- Freezer - Final Installment	2014	5,791						9
10	Door Closures	2014	3,483						10
11	Rooftop AC System Install	2014	8,950						11
12	Install Split System	2014	7,609						12
13	Parking Lot Fill, Seal and Stripe	2014	6,939						13
14	Replace Boiler and Water Tank	2014	9,928						14
15									15
16	Replace (6) PTAC units	2015	6,004						16
17	Repalce roof top refrigeration unit over dining room	2015	9,808						17
18	Repalcement of exhaust fans 1-5	2015	6,777						18
19									19
20	No 2016 Improvements								20
21									21
22	Install 12K Cooling/Heating unit	2017	2,639						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,392,904	\$ 174,085		\$ 174,085	\$	\$	34

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

Facility Name & ID Number Heritage Manor Carlinville LLC

# 48850

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	\$ 776,082	\$ 12,548	\$ 12,548	\$		\$	71
72	Current Year Purchases	12,404						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 788,486	\$ 12,548	\$ 12,548	\$		\$	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		2006 Turtle Top Van	2006	\$ 57,088	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 57,088	\$	\$	\$		\$	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)	\$ 5,270,495	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,633	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,633	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: \$ 8,506 Description: Televisions and office machines

(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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		4,961		4,961
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 4,961	\$	\$ 4,961
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	4,961		

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 379,968	\$		\$ 379,968	1
2	Licensed Speech and Language Development Therapist		hrs			14,899			14,899	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			242,509	365		242,874	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				408,827		408,827	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					23,307			23,307	13
14	TOTAL			\$		\$ 660,683	\$ 409,192		\$ 1,069,875	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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 304	\$	1
2	Cash-Patient Deposits	8,866		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	953,788		3
4	Supply Inventory (priced at FIFO )	13,118		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,622		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,233,811)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (1,254,113)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (1,254,113)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 66,130	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,866		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	278,894		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,222		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Bed Tax</u>	27,703		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 385,815	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 385,815	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,639,928)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (1,254,113)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,769,955)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,769,955)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>130,027</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>130,027</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,639,928)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Heritage Manor Carlinville LLC

# 48850

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,032,133	1
2	Discounts and Allowances for all Levels	(1,737,880)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,294,253	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,662,159	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,662,159	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	804,501	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	31,176	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 835,677	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	173	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 173	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,792,262	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	931,312	31
32	Health Care	2,272,056	32
33	General Administration	1,291,011	33
<b>B. Capital Expense</b>			
34	Ownership	530,259	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	637,597	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,662,235	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	130,027	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 130,027	43

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

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

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

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

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

Facility Name & ID Number Heritage Manor Carlinville LLC

# 48850

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	1,843	1,940	\$ 62,767	\$ 32.35	1
2	Assistant Director of Nursing	1,580	1,663	42,127	25.33	2
3	Registered Nurses	5,274	5,551	155,941	28.09	3
4	Licensed Practical Nurses	17,660	18,590	444,254	23.90	4
5	CNAs & Orderlies	57,961	61,012	769,439	12.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,552	3,739	88,653	23.71	8
9	Activity Director					9
10	Activity Assistants	4,684	4,930	69,819	14.16	10
11	Social Service Workers	1,778	1,872	37,022	19.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,193	18,098	197,463	10.91	15
16	Dishwashers					16
17	Maintenance Workers	4,561	4,801	68,036	14.17	17
18	Housekeepers	10,283	10,824	108,365	10.01	18
19	Laundry	5,369	5,651	58,368	10.33	19
20	Administrator	1,702	1,792	71,531	39.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,608	5,903	137,144	23.23	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)	139,048	146,366	\$ 2,310,929 *	\$ 15.79	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	15,000		36
37	Medical Records Consultant	917		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,214		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	3,736		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,867		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	39,911		52
53	TOTAL (lines 50 - 52)	\$ 39,911		53



Facility Name & ID Number Heritage Manor Carlinville LLC# 48850Report 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. \$ 214,804  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ 534
- (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 - Carlinville  
IDPH ID# 48850  
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	\$	408,827
Purchased Hospital Services		16,682
Purchased Laboratory Services		2,247
Purchased Radiology Services		4,378
Amount Reclassified to Line 39	\$	<u>432,134</u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	52,013
Provider Assessment Fee - \$6.70		162,791
Amount Reclassified to Line 42		<u>214,804</u>