

Facility Name & ID Number Heritage Manor Gillespie LLC

48900 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	100	Skilled (SNF)	100	36,500	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	100	TOTALS	100	36,500	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	10,865	7,501	3,066	21,432	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,865	7,501	3,066	21,432	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.72%

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 100 and days of care provided 3,066

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 Gillespie LLC # 48900 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	185,948	9,671		195,619		195,619	3,935	199,554		1
2	Food Purchase		160,971		160,971		160,971		160,971		2
3	Housekeeping	106,885	15,662		122,547		122,547	6	122,553		3
4	Laundry	51,031	13,089		64,120		64,120	1	64,121		4
5	Heat and Other Utilities			83,064	83,064		83,064	1,514	84,578		5
6	Maintenance	30,480	40,351	68,494	139,325		139,325	23,085	162,410		6
7	Other (specify):*										7
8	TOTAL General Services	374,344	239,744	151,558	765,646		765,646	28,541	794,187		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,276,838	77,646	7,322	1,361,806		1,361,806	15,316	1,377,122		10
10a	Therapy		450,439	47,550	497,989	(497,073)	916		916		10a
11	Activities	42,147	2,965		45,112		45,112		45,112		11
12	Social Services	39,070		1,083	40,153		40,153		40,153		12
13	CNA Training							1,086	1,086		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,358,055	531,050	73,955	1,963,060	(497,073)	1,465,987	16,402	1,482,389		16
	C. General Administration										
17	Administrative	88,041			88,041		88,041		88,041		17
18	Directors Fees										18
19	Professional Services			238,461	238,461		238,461	(220,511)	17,950		19
20	Dues, Fees, Subscriptions & Promotions			198,163	198,163	(171,585)	26,578	(9,933)	16,645		20
21	Clerical & General Office Expenses	140,139	26,695	14,965	181,799		181,799	362,613	544,412		21
22	Employee Benefits & Payroll Taxes			346,099	346,099		346,099	49,029	395,128		22
23	Inservice Training & Education			8,121	8,121		8,121	(3,122)	4,999		23
24	Travel and Seminar			1,609	1,609		1,609	3,390	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,236	38,236		38,236	11,828	50,064		26
27	Other (specify):*			49,200	49,200		49,200	(49,200)			27
28	TOTAL General Administration	228,180	26,695	894,854	1,149,729	(171,585)	978,144	144,094	1,122,238		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,960,579	797,489	1,120,367	3,878,435	(668,658)	3,209,777	189,037	3,398,814		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation							220,096	220,096		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			51,277	51,277		51,277	139,226	190,503		32
33	Real Estate Taxes							29,998	29,998		33
34	Rent-Facility & Grounds			516,840	516,840		516,840	(510,810)	6,030		34
35	Rent-Equipment & Vehicles			16,579	16,579		16,579	7,704	24,283		35
36	Other (specify):*										36
37	TOTAL Ownership			584,696	584,696		584,696	(113,786)	470,910		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			574,803	574,803	497,073	1,071,876	(143,561)	928,315		39
40	Barber and Beauty Shops		598	22,874	23,472		23,472		23,472		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					171,585	171,585		171,585		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		598	597,677	598,275	668,658	1,266,933	(143,561)	1,123,372		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,960,579	798,087	2,302,740	5,061,406		5,061,406	(68,310)	4,993,096		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	(2,529)			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	(4,705)			17
18	Fines and Penalties	(10,000)			18
19	Entertainment	(4,835)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,751)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,200)			24
25	Fund Raising, Advertising and Promotional	(8,103)			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)	\$ (82,123)		\$	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)	13,813		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,813		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (68,310)		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 Gillespie LLC

ID# 48900

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		(2,751)	19	22
23				23
24		(49,200)	27	24
25		(8,103)	20	25
26				26
27		(10,000)	20	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	(70,054)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Gillespie LLC# 48900

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	3,935	0	0	0	0	0	0	0	0	3,935	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	6	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	1	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	0	1,514	0	0	0	0	0	0	0	0	1,514	5
6	Maintenance	0	0	23,085	0	0	0	0	0	0	0	0	23,085	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	28,541	0	0	0	0	0	0	0	0	28,541	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	14,946	370	0	0	0	0	0	0	0	0	15,316	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	1,086	0	0	0	0	0	0	0	0	1,086	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	14,946	1,456	0	0	0	0	0	0	0	0	16,402	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	(2,751)	(234,451)	16,691	0	0	0	0	0	0	0	0	(220,511)	19
20	Fees, Subscriptions & Promotions	(18,103)	0	8,170	0	0	0	0	0	0	0	0	(9,933)	20
21	Clerical & General Office Expenses	0	0	362,613	0	0	0	0	0	0	0	0	362,613	21
22	Employee Benefits & Payroll Taxes	0	0	49,029	0	0	0	0	0	0	0	0	49,029	22
23	Inservice Training & Education	(4,705)	(102)	1,685	0	0	0	0	0	0	0	0	(3,122)	23
24	Travel and Seminar	(4,835)	0	8,225	0	0	0	0	0	0	0	0	3,390	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	11,828	0	0	0	0	0	0	0	0	11,828	26
27	Other (specify):*	(49,200)	0	0	0	0	0	0	0	0	0	0	(49,200)	27
28	TOTAL General Administration	(79,594)	(234,553)	458,241	0	0	0	0	0	0	0	0	144,094	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(79,594)	(219,607)	488,238	0	0	0	0	0	0	0	0	189,037	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Gillespie LLC# 48900

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	190,290	0	29,806	0	0	0	0	0	0	0	220,096	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,529)	140,021	0	1,734	0	0	0	0	0	0	0	139,226	32
33	Real Estate Taxes	0	29,998	0	0	0	0	0	0	0	0	0	29,998	33
34	Rent-Facility & Grounds	0	(516,840)	0	6,030	0	0	0	0	0	0	0	(510,810)	34
35	Rent-Equipment & Vehicles	0	0	0	7,704	0	0	0	0	0	0	0	7,704	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,529)	(156,531)	0	45,274	0	(113,786)	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	(143,561)	0	0	0	0	0	0	0	0	0	(143,561)	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	(143,561)	0	0	0	0	0	0	0	0	0	(143,561)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(82,123)	(519,699)	488,238	45,274	0	(68,310)	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		\$ 14,946	\$ 14,946	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(102)	(102)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(143,561)	(143,561)	3
4	V	19 Adjustment for Related Organization	234,451	Heritage Operations Group, LLC			(234,451)	4
5	V							5
6	V	34 Adjustment for Related Organization	516,840	Heritage Manor Real Estate, LLC			(516,840)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		29,998	29,998	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		138,128	138,128	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		190,290	190,290	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,893	1,893	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 751,291			\$ 231,592	\$ * (519,699)	14

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

Facility Name & ID Number Heritage Manor Gillespie LLC# 48900Report 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		\$	\$	3,935	15	
16	V	2 Food Purchase						0	16	
17	V	3 Housekeeping						6	17	
18	V	4 Laundry						1	18	
19	V	5 Heat & Other Utilities						1,514	19	
20	V	6 Maintenance						23,085	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						370	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,086	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						16,691	31	
32	V	20 Fees, Subscription, Promotions						8,170	32	
33	V	21 Clerical & General Office Expenses						362,613	33	
34	V	22 Employee Benefits & Payroll Taxes						49,029	34	
35	V	23 Inservice Training & Education						1,685	35	
36	V	24 Travel and Seminar						8,225	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						11,828	38	
39	Total		\$			\$	0	\$ *	488,238	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						29,806	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						1,734	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						6,030	20	
21	V	35 Rent-Equipment & Vehicles						7,704	21	
22	V	36 Other						0	22	
23	V	38 Medically Nec Transportation						0	23	
24	V	39 Ancillary Service Centers						0	24	
25	V	40 Barber and Beauty Shops						0	25	
26	V	41 Coffee and Gift Shops						0	26	
27	V	42 Other						0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	45,274	39

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

Facility Name & ID Number Heritage Manor Gillespie LLC # 48900 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 Gillespie LLC

48900

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	100	\$ 3,935	1
2	2	Food Purchase	Beds	2,578	26	0	0	100	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	100	6	3
4	4	Laundry	Beds	2,578	26	16	0	100	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	100	1,514	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	100	23,085	6
7	7	Other	Beds	2,578	26	0	0	100	0	7
8	9	Medical Director	Beds	2,578	26	0	0	100	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	100	370	9
10	11	Activities	Beds	2,578	26	0	0	100	0	10
11	12	Social Service	Beds	2,578	26	0	0	100	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	100	1,086	12
13	14	Program Transportation	Beds	2,578	26	0	0	100	0	13
14	15	Other	Beds	2,578	26	0	0	100	0	14
15	17	Administrative	Beds	2,578	26	0	0	100	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	100	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	100	16,691	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	100	8,170	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	100	362,613	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	100	49,029	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	100	1,685	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	100	8,225	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	100	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	100	11,828	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 488,238	25

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,578	26	\$	\$	100	\$	1
2	30	Depreciation	Beds	2,578	26	768,393		100	29,806	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26			100		3
4	32	Interest	Beds	2,578	26	44,696		100	1,734	4
5	33	Real Estate Taxes	Beds	2,578	26			100		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453		100	6,030	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602		100	7,704	7
8	36	Other	Beds	2,578	26			100		8
9	38	Medically Nec Transportation	Beds	2,578	26			100		9
10	39	Ancillary Service Centers	Beds	2,578	26			100		10
11	40	Barber and Beauty Shops	Beds	2,578	26			100		11
12	41	Coffee and Gift Shops	Beds	2,578	26			100		12
13	42	Other	Beds	2,578	26			100		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	\$		\$ 45,274	25

Facility Name & ID Number

Heritage Manor Gillespie LLC

48900

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	Busey Bank		x	Mortgage			\$	\$		\$ 138,128	1									
2	Busey Bank		x	Loan Fee Amortization						1,893	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						51,277	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 191,298	9									
B. Non-Facility Related*																				
10	Interest Income									(2,529)	10									
11											11									
12	Allocated Corporate									1,734	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (795)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 190,503	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.)		\$	29,998	2
3. Under or (over) accrual (line 2 minus line 1).		\$	29,998	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.		\$	29,998	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	30,785	8
	2013	30,748	9
	2014	30,528	10
	2015	30,540	11
	2016	29,998	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.

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

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

None

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

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: 1996, \$27,045, 1. Row 2: 2. Row 3: TOTALS, \$27,045, 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	100			\$ 3,578,055	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Roof Repair		1997	2,275					9
10	Storage Tank		1997	1,857					10
11									11
12	Heritage Manor Sign		1996	1,896					12
13	Laundry Room A/C		1996	3,019					13
14									14
15	Garbage Disposal		1998	730					15
16	Roof		1998	90,404					16
17									17
18	Water Heater		1999	3,596					18
19	Air Conditioning Unit		1999	1,145					19
20	Smoke Dampers/Fire Alarm Replacem		1999	5,802					20
21	Interior Painting--Materials and Labor		1999	2,459					21
22	Roof		1999	29,985					22
23									23
24	Interior Painting--Materials and Labor		2000	3,923					24
25									25
26	Booster Heater		2001	1,903					26
27	Telephone System Add-on		2001	62					27
28									28
29	A/C Rooftop Unit		2002	2,703					29
30									30
31									31
32									32
33	C/O Allocation				29,806		29,806		33
34	Book Depreciation				163,166		163,166		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 Gillespie LLC

48900

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	A/C Units	2003	\$ 8,858	\$		\$	\$	\$	37
38	Asphalt Sealing	2003	2,408						38
39	Ansul System --Kitchen	2003	1,465						39
40									40
41	Front Door	2004	3,893						41
42	Heat Cool Unit	2004	4,522						42
43									43
44	Windows	2005	6,255						44
45	HVAC	2005	10,675						45
46	Rooftop A/C	2005	6,663						46
47	Parking Lot Sealer	2005	2,358						47
48	Wallcoverings	2005	597						48
49	Sidewalks	2005	4,444						49
50	Floor Replacement	2005	18,756						50
51	Boiler	2005	6,388						51
52									52
53	A/C Units	2006	6,865						53
54	Rooftop A/C	2006	8,234						54
55	Five Ton Condensing Unit	2006	2,980						55
56	Pump	2006							56
57	Exterior Door	2006							57
58	Boiler	2006	5,396						58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,830,571	\$ 192,972		\$ 192,972	\$	\$	70

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

Facility Name & ID Number Heritage Manor Gillespie LLC# 48900

Report Period Beginning:

1/1/2017

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,830,571	\$ 192,972		\$ 192,972	\$	\$	1
2	HVAC	2007	3,430						2
3	Steamer Install	2007							3
4	Corridor Remodel	2007							4
5	HVAC	2007	3,024						5
6	Sprinkler Heads	2007	2,569						6
7	Boiler	2007	11,881						7
8	Plumbing	2007	2,949						8
9									9
10	Facility Rehab -- Paint, flooring, lighting	2008	227,268						10
11	Exterior Door	2008	4,150						11
12	Boilers	2008	16,293						12
13	Nurse Call System	2008	123,168						13
14	Window Replacement	2008	54,925						14
15	Parking Lot	2008	37,142						15
16	Wireless System	2008	10,017						16
17	Cabling	2008	5,785						17
18	Alarm System	2008	8,804						18
19									19
20	Rehab: Paint, window treatments, paint & labor	2009	27,218						20
21	Landscaping rock	2009	4,501						21
22	Rooftop A/C	2009	8,678						22
23	Sewer pump	2009	9,150						23
24	Nurse Call System	2009	88,196						24
25									25
26	Carpeting: conference room		2,929						26
27	Relocate/Install data equipment		10,251						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,492,899	\$ 192,972		\$ 192,972	\$	\$	34

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

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		\$ 4,492,899	\$ 192,972		\$ 192,972	\$	\$	1
2	PTAC units	2011	7,591						2
3	Condensing Unit	2011	5,461						3
4	Condensing Unit	2011	11,480						4
5	Carpet	2011	24,911						5
6	PTAC units	2011	3,796						6
7	Resident Room Flooring	2011	13,125						7
8									8
9	Carpet	2012	3,332						9
10	Shower Room	2012	8,493						10
11	Water Heater	2012	3,632						11
12	Walk-in Cooler	2012	33,299						12
13	Lighting Upgrade	2012	5,446						13
14									14
15	Front Parking Lot Paving	2013	53,996						15
16	Water Heater	2013	6,750						16
17	PTAC Units	2013	4,089						17
18									18
19	Replace 6 PTAC Units	2014	6,686						19
20	Remove and Rebuild Exterior Wall	2014	8,583						20
21	Parking Lot Fill, Seal and Striping	2014	4,386						21
22									22
23	Install (6) new PTAC units	2015	9,604						23
24	Replacement of air conditioning unit - therapy	2015	6,035						24
25	Install bath, shower and wall tile - bathing room	2015	6,833						25
26									26
27	Install new 100 gallon water heater	2016	5,200						27
28									28
29	AC System installation - Laundry	2017	3,591						29
30	Removed carpet and replace with tile flooring in	2017	15,129						30
31	rooms damaged by flooding; removed and replaced damaged drywall								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,744,347	\$ 192,972		\$ 192,972	\$	\$	34

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

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	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		\$ 4,744,347	\$ 192,972		\$ 192,972	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 4,744,347	\$ 192,972		\$ 192,972	\$	\$

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

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	\$ 979,268	\$ 27,124	\$ 27,124	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 979,268	\$ 27,124	\$ 27,124	\$		\$	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		Turtle Top Van	2006	\$ 28,611	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 28,611	\$	\$	\$		\$	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)	\$ 5,779,271	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,096	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 220,096	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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: \$ 16,579 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>
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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	\$		\$ 347,162	\$		\$ 347,162	1
2	Licensed Speech and Language Development Therapist		hrs			55,297			55,297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			172,344	916		173,260	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				449,523		449,523	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					47,550			47,550	13
14	TOTAL			\$		\$ 622,353	\$ 450,439		\$ 1,072,792	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 444	\$	1
2	Cash-Patient Deposits	25,211		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	588,593		3
4	Supply Inventory (priced at FIFO)	11,728		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,504		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(107,547)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 519,933	\$	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)	\$ 519,933	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,686	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,211		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	281,960		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,280		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>	18,289		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 367,426	\$	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)	\$ 367,426	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 152,507	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 519,933	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 356,324	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 356,324	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(203,817)	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)	\$ (203,817)	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)	\$ 152,507	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	\$ 4,477,963	1
2	Discounts and Allowances for all Levels	(2,020,992)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,456,971	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,506,391	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,506,391	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,025	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	876,808	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,865	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 891,698	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,529	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,529	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)	\$ 4,857,589	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	765,646	31
32	Health Care	1,963,060	32
33	General Administration	1,149,729	33
B. Capital Expense			
34	Ownership	584,696	34
C. Ancillary Expense			
35	Special Cost Centers	598,275	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)*	\$ 5,061,406	40
41	Income before Income Taxes (line 30 minus line 40)**	(203,817)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (203,817)	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 Gillespie LLC

48900

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	1,777	1,871	\$ 67,110	\$ 35.87	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	1,821	1,917	55,844	29.13	3
4	Licensed Practical Nurses	17,595	18,521	435,024	23.49	4
5	CNAs & Orderlies	44,279	46,610	657,780	14.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,191	2,306	61,080	26.49	8
9	Activity Director					9
10	Activity Assistants	3,392	3,570	42,147	11.81	10
11	Social Service Workers	1,721	1,811	39,070	21.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,107	15,902	185,948	11.69	15
16	Dishwashers					16
17	Maintenance Workers	1,789	1,883	30,480	16.19	17
18	Housekeepers	9,331	9,822	106,885	10.88	18
19	Laundry	3,945	4,152	51,031	12.29	19
20	Administrator	1,786	1,880	88,041	46.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,236	5,511	140,139	25.43	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)	109,970	115,756	\$ 1,960,579 *	\$ 16.94	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	1,284		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,586		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,063		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,933		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	0		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Heritage Manor Gillespie LLC# 48900Report 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. \$ 171,585
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. \$ 723
- (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 - Gillespie
IDPH ID# 48900
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	\$	449,523
Purchased Hospital Services		35,836
Purchased Laboratory Services		5,851
Purchased Radiology Services		5,863
Amount Reclassified to Line 39	\$	<u>497,073</u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	54,750
Provider Assessment Fee - \$6.70		116,835
Amount Reclassified to Line 42		<u>171,585</u>