

Facility Name & ID Number Heritage Manor Mt. Zion LLC

48074 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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	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	15,737	4,484	3,330	23,551	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,737	4,484	3,330	23,551	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.03%

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 75 and days of care provided 3,330

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 Mt. Zion LLC # 48074 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	182,588	16,646		199,234		199,234	2,951	202,185		1
2	Food Purchase		161,427		161,427		161,427		161,427		2
3	Housekeeping	66,190	24,209		90,399		90,399	4	90,403		3
4	Laundry	92,810	8,321		101,131		101,131		101,131		4
5	Heat and Other Utilities			109,493	109,493		109,493	1,135	110,628		5
6	Maintenance	44,652	57,902	54,090	156,644		156,644	17,314	173,958		6
7	Other (specify):*										7
8	TOTAL General Services	386,240	268,505	163,583	818,328		818,328	21,404	839,732		8
	B. Health Care and Programs										
9	Medical Director			22,680	22,680		22,680		22,680		9
10	Nursing and Medical Records	1,375,220	115,843	93,880	1,584,943		1,584,943	(23,840)	1,561,103		10
10a	Therapy		527,264	9,259	536,523	(535,306)	1,217		1,217		10a
11	Activities	70,113	1,373		71,486		71,486		71,486		11
12	Social Services	38,162		8,318	46,480		46,480		46,480		12
13	CNA Training							814	814		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,483,495	644,480	134,137	2,262,112	(535,306)	1,726,806	(23,026)	1,703,780		16
	C. General Administration										
17	Administrative	91,977			91,977		91,977		91,977		17
18	Directors Fees										18
19	Professional Services			277,237	277,237		277,237	(263,287)	13,950		19
20	Dues, Fees, Subscriptions & Promotions			188,595	188,595	(162,961)	25,634	(11,642)	13,992		20
21	Clerical & General Office Expenses	154,010	21,862	7,286	183,158		183,158	271,960	455,118		21
22	Employee Benefits & Payroll Taxes			388,991	388,991		388,991	36,772	425,763		22
23	Inservice Training & Education			6,868	6,868		6,868	(1,869)	4,999		23
24	Travel and Seminar			4,521	4,521		4,521	478	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			26,279	26,279		26,279	8,871	35,150		26
27	Other (specify):*			6,000	6,000		6,000	(6,000)			27
28	TOTAL General Administration	245,987	21,862	905,777	1,173,626	(162,961)	1,010,665	35,283	1,045,948		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,115,722	934,847	1,203,497	4,254,066	(698,267)	3,555,799	33,661	3,589,460		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							100,144	100,144		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			38,459	38,459		38,459	36,649	75,108		32
33	Real Estate Taxes							66,816	66,816		33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,978)	4,522		34
35	Rent-Equipment & Vehicles			26,026	26,026		26,026	5,778	31,804		35
36	Other (specify):*										36
37	TOTAL Ownership			392,985	392,985		392,985	(114,591)	278,394		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			718,167	718,167	535,306	1,253,473	(156,692)	1,096,781		39
40	Barber and Beauty Shops		15,475	590	16,065		16,065		16,065		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					162,961	162,961		162,961		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		15,475	718,757	734,232	698,267	1,432,499	(156,692)	1,275,807		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,115,722	950,322	2,315,239	5,381,283		5,381,283	(237,622)	5,143,661		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	(14,675)			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	(2,997)			17
18	Fines and Penalties	(10,000)			18
19	Entertainment	(5,691)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,146)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(7,770)			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)	\$ (69,279)		\$	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)	(168,343)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (168,343)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (237,622)		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 Mt. Zion LLC

ID# 48074

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		(22,146)	19	22
23				23
24		(6,000)	27	24
25		(7,770)	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	(45,916)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Mt. Zion LLC# 48074

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	2,951	0	0	0	0	0	0	0	0	2,951	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,135	0	0	0	0	0	0	0	0	1,135	5
6	Maintenance	0	0	17,314	0	0	0	0	0	0	0	0	17,314	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	21,404	0	21,404	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	(24,118)	278	0	0	0	0	0	0	0	0	(23,840)	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	814	0	0	0	0	0	0	0	0	814	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	(24,118)	1,092	0	(23,026)	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	(22,146)	(253,659)	12,518	0	0	0	0	0	0	0	0	(263,287)	19
20	Fees, Subscriptions & Promotions	(17,770)	0	6,128	0	0	0	0	0	0	0	0	(11,642)	20
21	Clerical & General Office Expenses	0	0	271,960	0	0	0	0	0	0	0	0	271,960	21
22	Employee Benefits & Payroll Taxes	0	0	36,772	0	0	0	0	0	0	0	0	36,772	22
23	Inservice Training & Education	(2,997)	(136)	1,264	0	0	0	0	0	0	0	0	(1,869)	23
24	Travel and Seminar	(5,691)	0	6,169	0	0	0	0	0	0	0	0	478	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	8,871	0	0	0	0	0	0	0	0	8,871	26
27	Other (specify):*	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	27
28	TOTAL General Administration	(54,604)	(253,795)	343,682	0	35,283	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,604)	(277,913)	366,178	0	33,661	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Mt. Zion LLC # 48074 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	0	77,790	0	22,354	0	0	0	0	0	0	0	100,144	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,675)	50,024	0	1,300	0	0	0	0	0	0	0	36,649	32
33	Real Estate Taxes	0	66,816	0	0	0	0	0	0	0	0	0	66,816	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,522	0	0	0	0	0	0	0	(323,978)	34
35	Rent-Equipment & Vehicles	0	0	0	5,778	0	0	0	0	0	0	0	5,778	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,675)	(133,870)	0	33,954	0	(114,591)	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	(156,692)	0	0	0	0	0	0	0	0	0	(156,692)	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	(156,692)	0	0	0	0	0	0	0	0	0	(156,692)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,279)	(568,475)	366,178	33,954	0	(237,622)	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		\$ (24,118)	\$	(24,118)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(136)		(136)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(156,692)		(156,692)	3
4	V	19 Adjustment for Related Organization	253,659	Heritage Operations Group, LLC				(253,659)	4
5	V								5
6	V	34 Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC				(328,500)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		66,816		66,816	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		45,363		45,363	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		77,790		77,790	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,661		4,661	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 582,159			\$ 13,684	\$ *	(568,475)	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		\$	\$ 2,951	15
16	V	2 Food Purchase					0	16
17	V	3 Housekeeping					4	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,135	19
20	V	6 Maintenance					17,314	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					278	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					814	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					0	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					12,518	31
32	V	20 Fees, Subscription, Promotions					6,128	32
33	V	21 Clerical & General Office Expenses					271,960	33
34	V	22 Employee Benefits & Payroll Taxes					36,772	34
35	V	23 Inservice Training & Education					1,264	35
36	V	24 Travel and Seminar					6,169	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					8,871	38
39	Total		\$			\$	0	\$ * 366,178 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						22,354	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						1,300	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						4,522	20	
21	V	35 Rent-Equipment & Vehicles						5,778	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	\$ *	33,954	39

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

Facility Name & ID Number Heritage Manor Mt. Zion LLC # 48074 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 Mt. Zion LLC

48074

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	1	Dietary	Beds	2,578	26	\$ 101,433	\$ 109,431	75	\$ 2,951	1
2	2	Food Purchase	Beds	2,578	26	0	0	75	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	75	4	3
4	4	Laundry	Beds	2,578	26	16	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	75	1,135	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	75	17,314	6
7	7	Other	Beds	2,578	26	0	0	75	0	7
8	9	Medical Director	Beds	2,578	26	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	75	278	9
10	11	Activities	Beds	2,578	26	0	0	75	0	10
11	12	Social Service	Beds	2,578	26	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	75	814	12
13	14	Program Transportation	Beds	2,578	26	0	0	75	0	13
14	15	Other	Beds	2,578	26	0	0	75	0	14
15	17	Administrative	Beds	2,578	26	0	0	75	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	75	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	75	12,518	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	75	6,128	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	75	271,960	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	75	36,772	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	75	1,264	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	75	6,169	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	75	8,871	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 366,178	25

Facility Name & ID Number Heritage Manor Mt. Zion LLC

48074

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,578	26	\$	75	\$	1
2	30	Depreciation	Beds	2,578	26	768,393	75	22,354	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		75		3
4	32	Interest	Beds	2,578	26	44,696	75	1,300	4
5	33	Real Estate Taxes	Beds	2,578	26		75		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	75	4,522	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	75	5,778	7
8	36	Other	Beds	2,578	26		75		8
9	38	Medically Nec Transportation	Beds	2,578	26		75		9
10	39	Ancillary Service Centers	Beds	2,578	26		75		10
11	40	Barber and Beauty Shops	Beds	2,578	26		75		11
12	41	Coffee and Gift Shops	Beds	2,578	26		75		12
13	42	Other	Beds	2,578	26		75		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	\$	\$ 33,954	25

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.)		\$	66,816	2
3. Under or (over) accrual (line 2 minus line 1).		\$	66,816	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.		\$	66,816	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	61,050	8	
	2013	61,882	9	
	2014	62,358	10	
	2015	64,686	11	
	2016	66,816	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Mt. Zion LLC COUNTY Macon

FACILITY IDPH LICENSE NUMBER 48074

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>121704210003</u>	_____	\$ <u>66,816.28</u>	\$ <u>66,816.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>66,816.28</u></u>	\$ <u><u>66,816.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Heritage Manor Mt. Zion LLC

48074

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,920 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

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: Use, Square Feet, Year Acquired 1998, Cost 50,000, 1. Row 2: Use, Square Feet, Year Acquired, Cost, 2. Row 3: TOTALS, Square Feet, Year Acquired, Cost 50,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	75			\$ 1,076,000	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Environmental Site Study		1998	1,662					9
10	Sign		1998	1,860					10
11	Air conditioning Unit		1999	5,732					11
12	Air Conditioner		1999	750					12
13	Professional Fees --Remodeling Project		1999	15,922					13
14									14
15	Facility Remodel -- Materials		2000	241,637					15
16	Professional Fees --Remodeling Project		2000	58,519					16
17	Kitchen A/C		2000	990					17
18	Fire Alarm		2000	1,997					18
19	Door Guard System		2000	3,444					19
20									20
21	Smoke Detectors		2001	3,775					21
22	Water Main Break		2001	3,426					22
23	Commercial Disposer		2001	757					23
24	Heat Pump		2001	5,158					24
25	Carpet Extract		2001	1,206					25
26			2001						26
27	Facility Remodel -- Contractor		2001	1,397,646					27
28	Professional Fees --Remodeling Project		2001	45,077					28
29									29
30	Facility Remodel -- Contractor		2002	2,762					30
31	Fire Dampers		2002	2,766					31
32									32
33	C/O Allocation				22,354		22,354		33
34	Book Depreciation				61,564		61,564		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 Mt. Zion LLC

48074

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	Asphalt Sealing	2003	\$ 1,447	\$		\$	\$	\$	37
38	Sprinklers	2003	2,680						38
39	Storm Windows	2003	1,173						39
40									40
41	Water Heater	2004	1,114						41
42	Disposal	2004	871						42
43									43
44	A/C Laundry Room	2005	2,968						44
45									45
46	Sidewalk	2006	4,080						46
47	Parking Lot Sealcoat	2006	2,225						47
48	Dishroom rehab	2006	3,631						48
49	Oxygen storage room rehab	2006	3,858						49
50	Fire Alarm	2006	2,249						50
51									51
52									52
53									53
54									54
55	Storage Garage	2007	23,848						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58									58
59									59
60	Window Replacement	2009	56,034						60
61	HVAC	2009	2,656						61
62	HVAC rooftop	2009	9,250						62
63	Water Heater	2009	7,925						63
64	Parking Lot Sealcoat	2009	31,071						64
65									65
66	Water Heater	2010	16,232						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,056,165	\$ 83,918		\$ 83,918	\$	\$	70

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

Facility Name & ID Number Heritage Manor Mt. Zion LLC

48074

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		\$ 3,056,165	\$ 83,918		\$ 83,918	\$	\$	1
2									2
3	Nurse Call & technology system	2011	184,918						3
4	Carpet	2011	9,016						4
5	Medicare lift	2011	8,334						5
6	Asbestos Abatement	2011	11,601						6
7	Heat Exchange	2011	5,637						7
8	Air Handler Unit	2011	4,714						8
9									9
10	Addison air unit	2012	2,940						10
11	Cast Iron Pipe	2012	3,208						11
12	Generator Control	2012	3,362						12
13	Nurse Call & technology system	2012	3,636						13
14									14
15	Flooring - Room 10	2013	3,173						15
16	Lighting Retrofit	2013	2,887						16
17									17
18	Install Replacement Split System - Laundry Room	2014	9,800						18
19	Schematic Design Fees - Facility Renovation Project	2014	8,428						19
20									20
21	Schematic Design Fees - Facility Renovation Project	2015	2,101						21
22	Install (8) six gallon electric water heaters	2015	6,930						22
23	Replace compressor on walk-in freezer	2015	3,843						23
24									24
25	No Improvements made in 2016								25
26									26
27	Removed and replaced heat exchangers in both north	2017	10,601						27
28	and south wings								28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,341,294	\$ 83,918		\$ 83,918	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 746,734	\$ 16,226	\$ 16,226	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 746,734	\$ 16,226	\$ 16,226	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 4,138,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,144	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,144	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 Mt. Zion LLC

48074

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: \$ 26,026 Description: Televisions and Office equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 390,924	\$		\$ 390,924	1
2	Licensed Speech and Language Development Therapist		hrs			56,284			56,284	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			270,959	1,217		272,176	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				526,047		526,047	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,259			9,259	13
14	TOTAL			\$		\$ 727,426	\$ 527,264		\$ 1,254,690	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	\$ 4,681	\$	1
2	Cash-Patient Deposits	11,219		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,011,898		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	772		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,023,675)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,895	\$	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)	\$ 4,895	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 68,583	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,219		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,905		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,680		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>	20,753		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 267,140	\$	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)	\$ 267,140	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (262,245)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,895	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (96,712)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (96,712)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(165,533)	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)	\$ (165,533)	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)	\$ (262,245)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor Mt. Zion LLC

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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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,561,197	1
2	Discounts and Allowances for all Levels	(2,372,572)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,188,625	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,965,270	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,965,270	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	16,577	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,031,315	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(716)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,047,176	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,675	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,675	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund	4	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,215,750	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	818,328	31
32	Health Care	2,262,112	32
33	General Administration	1,173,626	33
B. Capital Expense			
34	Ownership	392,985	34
C. Ancillary Expense			
35	Special Cost Centers	734,232	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)*	\$ 5,381,283	40
41	Income before Income Taxes (line 30 minus line 40)**	(165,533)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (165,533)	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 Mt. Zion LLC

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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	1,841	1,938	\$ 68,325	\$ 35.26	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	11,372	11,971	366,685	30.63	3
4	Licensed Practical Nurses	10,022	10,549	262,558	24.89	4
5	CNAs & Orderlies	46,086	48,512	638,027	13.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,295	1,363	39,625	29.07	8
9	Activity Director					9
10	Activity Assistants	4,428	4,661	70,113	15.04	10
11	Social Service Workers	1,558	1,640	38,162	23.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,871	15,654	182,588	11.66	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,026	44,652	22.04	17
18	Housekeepers	5,743	6,045	66,190	10.95	18
19	Laundry	6,260	6,590	92,810	14.08	19
20	Administrator	1,923	2,024	91,977	45.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,193	6,519	154,010	23.62	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)	113,516	119,492	\$ 2,115,722 *	\$ 17.71	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	22,680		36
37	Medical Records Consultant	8,492		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,229		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	8,318		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 43,719		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 42,002		50
51	Licensed Practical Nurses	1,263		51
52	Certified Nurse Assistants/Aides	37,894		52
53	TOTAL (lines 50 - 52)	\$ 81,159		53

Facility Name & ID Number Heritage Manor Mt. Zion LLC

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Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 162,961
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. \$ 632
- (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 - Mt. Zion
IDPH ID# 48074
HFS Cost Report - December 31, 2017
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	526,047
Purchased Hospital Services		3,634
Purchased Laboratory Services		5,601
Purchased Radiology Services		24
Amount Reclassified to Line 39	\$	<u>535,306</u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	41,063
Provider Assessment Fee - \$6.70		121,898
Amount Reclassified to Line 42		<u>162,961</u>