



Facility Name & ID Number Heritage Manor Pana LLC

# 48884 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	128	Skilled (SNF)	128	46,720	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	128	TOTALS	128	46,720	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	22,183	7,275	6,598	36,056	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,183	7,275	6,598	36,056	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 77.17%

**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 128 and days of care provided 6,598

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 Pana LLC # 48884 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	272,857	27,140		299,997		299,997	5,036	305,033		1
2	Food Purchase		276,790		276,790		276,790		276,790		2
3	Housekeeping	110,367	37,198		147,565		147,565	7	147,572		3
4	Laundry	60,623	23,956		84,579		84,579	1	84,580		4
5	Heat and Other Utilities			148,645	148,645		148,645	1,937	150,582		5
6	Maintenance	115,910	101,160	73,384	290,454		290,454	29,549	320,003		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	559,757	466,244	222,029	1,248,030		1,248,030	36,530	1,284,560		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			17,000	17,000		17,000		17,000		9
10	Nursing and Medical Records	2,517,350	170,764	20,189	2,708,303		2,708,303	(23,457)	2,684,846		10
10a	Therapy		768,067	72,142	840,209	(836,239)	3,970		3,970		10a
11	Activities	58,938	1,507		60,445		60,445		60,445		11
12	Social Services	53,419		3,490	56,909		56,909		56,909		12
13	CNA Training	3,603		3,293	6,896		6,896	1,390	8,286		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,633,310	940,338	116,114	3,689,762	(836,239)	2,853,523	(22,067)	2,831,456		16
	<b>C. General Administration</b>										
17	Administrative	82,151			82,151		82,151		82,151		17
18	Directors Fees										18
19	Professional Services			454,787	454,787		454,787	(432,268)	22,519		19
20	Dues, Fees, Subscriptions & Promotions			286,369	286,369	(250,462)	35,907	(3,750)	32,157		20
21	Clerical & General Office Expenses	268,454	26,861	9,132	304,447		304,447	464,145	768,592		21
22	Employee Benefits & Payroll Taxes			649,842	649,842		649,842	62,757	712,599		22
23	Inservice Training & Education			10,598	10,598		10,598	(5,599)	4,999		23
24	Travel and Seminar			10,153	10,153		10,153	(5,154)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,270	49,270		49,270	15,140	64,410		26
27	Other (specify):* <b>Lost resident items</b>			15,723	15,723		15,723	(15,600)	123		27
28	<b>TOTAL General Administration</b>	350,605	26,861	1,485,874	1,863,340	(250,462)	1,612,878	79,671	1,692,549		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,543,672	1,433,443	1,824,017	6,801,132	(1,086,701)	5,714,431	94,134	5,808,565		29

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

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

Facility Name &amp; ID Number

Heritage Manor Pana LLC

#48884

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							320,954	320,954			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,635	65,635		65,635	186,428	252,063			32
33	Real Estate Taxes							73,397	73,397			33
34	Rent-Facility & Grounds			663,800	663,800		663,800	(656,082)	7,718			34
35	Rent-Equipment & Vehicles			51,561	51,561		51,561	9,861	61,422			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			780,996	780,996		780,996	(65,442)	715,554			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,401,943	1,401,943	836,239	2,238,182	(232,260)	2,005,922			39
40	Barber and Beauty Shops		1,959	20,750	22,709		22,709		22,709			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					250,462	250,462		250,462			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,959	1,422,693	1,424,652	1,086,701	2,511,353	(232,260)	2,279,093			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,543,672	1,435,402	4,027,706	9,006,780		9,006,780	(203,568)	8,803,212			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	(5,622)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(7,688)			17
18	Fines and Penalties				18
19	Entertainment	(15,683)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,579)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,600)			24
25	Fund Raising, Advertising and Promotional	(14,208)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (62,380)		\$	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)	(141,188)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (141,188)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (203,568)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Heritage Manor Pana LLC

ID# 48884

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		(3,579)	19	22
23				23
24		(15,600)	27	24
25		(14,208)	20	25
26				26
27		0	29	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(33,387)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Pana LLC# 48884

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	5,036	0	0	0	0	0	0	0	0	5,036	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	7	0	0	0	0	0	0	0	0	7	3
4	Laundry	0	0	1	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	0	1,937	0	0	0	0	0	0	0	0	1,937	5
6	Maintenance	0	0	29,549	0	0	0	0	0	0	0	0	29,549	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>36,530</b>	<b>0</b>	<b>36,530</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(23,931)	474	0	0	0	0	0	0	0	0	(23,457)	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	1,390	0	0	0	0	0	0	0	0	1,390	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(23,931)</b>	<b>1,864</b>	<b>0</b>	<b>(22,067)</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,579)	(450,053)	21,364	0	0	0	0	0	0	0	0	(432,268)	19
20	Fees, Subscriptions & Promotions	(14,208)	0	10,458	0	0	0	0	0	0	0	0	(3,750)	20
21	Clerical & General Office Expenses	0	0	464,145	0	0	0	0	0	0	0	0	464,145	21
22	Employee Benefits & Payroll Taxes	0	0	62,757	0	0	0	0	0	0	0	0	62,757	22
23	Inservice Training & Education	(7,688)	(68)	2,157	0	0	0	0	0	0	0	0	(5,599)	23
24	Travel and Seminar	(15,683)	0	10,529	0	0	0	0	0	0	0	0	(5,154)	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	15,140	0	0	0	0	0	0	0	0	15,140	26
27	Other (specify):*	(15,600)	0	0	0	0	0	0	0	0	0	0	(15,600)	27
28	<b>TOTAL General Administration</b>	<b>(56,758)</b>	<b>(450,121)</b>	<b>586,550</b>	<b>0</b>	<b>79,671</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(56,758)</b>	<b>(474,052)</b>	<b>624,944</b>	<b>0</b>	<b>94,134</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Pana LLC # 48884 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	282,803	0	38,151	0	0	0	0	0	0	0	320,954	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,622)	189,831	0	2,219	0	0	0	0	0	0	0	186,428	32
33	Real Estate Taxes	0	73,397	0	0	0	0	0	0	0	0	0	73,397	33
34	Rent-Facility & Grounds	0	(663,800)	0	7,718	0	0	0	0	0	0	0	(656,082)	34
35	Rent-Equipment & Vehicles	0	0	0	9,861	0	0	0	0	0	0	0	9,861	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,622)</b>	<b>(117,769)</b>	<b>0</b>	<b>57,949</b>	<b>0</b>	<b>(65,442)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(232,260)	0	0	0	0	0	0	0	0	0	(232,260)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>(232,260)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(232,260)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(62,380)</b>	<b>(824,081)</b>	<b>624,944</b>	<b>57,949</b>	<b>0</b>	<b>(203,568)</b>	<b>45</b>						

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (23,931)	\$ (23,931)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(68)	(68)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(232,260)	(232,260)	3
4	V	19 Adjustment for Related Organization	450,053	Heritage Operations Group, LLC			(450,053)	4
5	V							5
6	V	34 Adjustment for Related Organization	663,800	Heritage Manor Real Estate, LLC			(663,800)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		73,397	73,397	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		172,116	172,116	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		282,803	282,803	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		17,715	17,715	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,113,853			\$ 289,772	\$ * (824,081)	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		\$	\$	5,036	15	
16	V	2 Food Purchase						0	16	
17	V	3 Housekeeping						7	17	
18	V	4 Laundry						1	18	
19	V	5 Heat & Other Utilities						1,937	19	
20	V	6 Maintenance						29,549	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						474	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,390	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						21,364	31	
32	V	20 Fees, Subscription, Promotions						10,458	32	
33	V	21 Clerical & General Office Expenses						464,145	33	
34	V	22 Employee Benefits & Payroll Taxes						62,757	34	
35	V	23 Inservice Training & Education						2,157	35	
36	V	24 Travel and Seminar						10,529	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						15,140	38	
39	<b>Total</b>		\$			\$	0	\$ *	624,944	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						38,151 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						2,219 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						7,718 20
21	V	35 Rent-Equipment & Vehicles						9,861 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	\$	0 * 57,949 39

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

Facility Name &amp; ID Number

Heritage Manor Pana LLC

# 48884

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 Pana LLC

# 48884

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	128	\$ 5,036	1
2	2	Food Purchase	Beds	2,578	26	0	0	128	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	128	7	3
4	4	Laundry	Beds	2,578	26	16	0	128	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	128	1,937	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	128	29,549	6
7	7	Other	Beds	2,578	26	0	0	128	0	7
8	9	Medical Director	Beds	2,578	26	0	0	128	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	128	474	9
10	11	Activities	Beds	2,578	26	0	0	128	0	10
11	12	Social Service	Beds	2,578	26	0	0	128	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	128	1,390	12
13	14	Program Transportation	Beds	2,578	26	0	0	128	0	13
14	15	Other	Beds	2,578	26	0	0	128	0	14
15	17	Administrative	Beds	2,578	26	0	0	128	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	128	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	128	21,364	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	128	10,458	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	128	464,145	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	128	62,757	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	128	2,157	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	128	10,529	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	128	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	128	15,140	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 624,944	25

Facility Name & ID Number Heritage Manor Pana LLC

# 48884

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	\$	128	\$	1
2	30	Depreciation	Beds	2,578	26	768,393	128	38,151	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		128		3
4	32	Interest	Beds	2,578	26	44,696	128	2,219	4
5	33	Real Estate Taxes	Beds	2,578	26		128		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	128	7,718	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	128	9,861	7
8	36	Other	Beds	2,578	26		128		8
9	38	Medically Nec Transportation	Beds	2,578	26		128		9
10	39	Ancillary Service Centers	Beds	2,578	26		128		10
11	40	Barber and Beauty Shops	Beds	2,578	26		128		11
12	41	Coffee and Gift Shops	Beds	2,578	26		128		12
13	42	Other	Beds	2,578	26		128		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	\$	\$ 57,949	25







Facility Name & ID Number Heritage Manor Pana LLC

# 48884

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,600 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

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

If so, please complete the following:

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1996	\$ 51,055	1
2					2
3	TOTALS			\$ 51,055	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	128			\$ 3,943,054	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Smoke Detectors		1997	1,113					
10									
11	Seal BlackTop/Parking Lot		1996	2,680					
12	Heritage Manor Sign		1996	2,192					
13	Laundry Room Central A/C		1996	3,019					
14									
15	Generator Repair		1998	1,559					
16	Roof		1998	26,420					
17									
18	roof		1999	113,936					
19									
20	Heat / Cool Unit		2000	1,170					
21	Roof Repair Walkway		2000	1,715					
22									
23									
24	Tile Floor		2001	1,646					
25	Heat/Cool Unit		2001	1,180					
26									
27	Day Room Carpet		2002	1,225					
28	Hot Water Heater		2002	2,224					
29	Sewar repair		2002	1,965					
30									
31									
32									
33	C/O Allocation				38,151		38,151		
34	Book Depreciation				249,832		249,832		
35									
36									

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor Pana LLC

# 48884

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	Sealcoat Parking Lot	2003	\$ 3,338	\$		\$	\$	\$	37
38	A/C unit	2003	1,153						38
39									39
40	Carpeting	2003	5,655						40
41	Ansul System	2003	1,803						41
42									42
43	Booster Heater	2004	1,151						43
44	Energy Mgt System	2004	12,890						44
45	Exterior Doors	2004	1,247						45
46	Heat/Cool Units	2004	7,372						46
47	Drive way repairs	2004	1,765						47
48	Carpeting	2004	13,652						48
49	Sewer Replacement	2004	2,847						49
50									50
51	Heat/Cool Units	2005	13,286						51
52	Underfloor Ductwork	2005	1,100						52
53	Sidewalks	2005	9,208						53
54	Roof	2005	4,161						54
55									55
56	Sewer Replacement	2006	13,522						56
57	A/C unit	2006	5,660						57
58	Resident Room Carpet	2006	11,370						58
59	Parking Lot Resurface	2006	47,908						59
60	Remodel Dinning Room	2006	4,854						60
61	Fire Alarm Panel	2006	531						61
62	Capital Report Adj	2006	(5,385)						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,264,186	\$ 287,983		\$ 287,983	\$	\$	70

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

Facility Name &amp; ID Number Heritage Manor Pana LLC

# 48884

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,264,186	\$ 287,983		\$ 287,983	\$	\$	1
2	Fire alarm	2007	44,843						2
3	HVAC	2007	12,000						3
4	Secire Care System	2007	9,092						4
5	Carpet	2007	13,896						5
6	Roof	2007	16,120						6
7									7
8									8
9	A/C Units	2008	7,182						9
10	Remodel Medicare Rooms - Paint	2008	5,392						10
11	Plumbing	2008	6,634						11
12	Parking Lot Resurface	2008	48,871						12
13	Roof	2008	4,492						13
14	Water Heater	2008	4,275						14
15									15
16									16
17	Water Heater	2009	9,128						17
18	Nurse Call & phone system	2009	279,962						18
19									19
20									20
21									21
22	General Conditions & Demolition	2009	77,349						22
23	Carpentry & Millwork	2009	248,504						23
24	Acoustical Ceiling & Flooring	2009	71,696						24
25	Painting	2009	93,983						25
26	Plumbing	2009	42,683						26
27	Electrical	2009	50,534						27
28	Design and layout	2009	30,556						28
29	Project Materials	2009	145,671						29
30	Telephone cables, ceiling tile & kick plates	2009	8,500						30
31	Nurse Station Modifications	2009	3,410						31
32	Ceiling tiles	2009	3,923						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,502,882	\$ 287,983		\$ 287,983	\$	\$	34

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

Facility Name &amp; ID Number Heritage Manor Pana LLC

# 48884

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,502,882	\$ 287,983		\$ 287,983	\$	\$	1
2									2
3	Light fixtures	2009	3,179						3
4									4
5									5
6									6
7	Soft Goods, asbestos removal and materials	2010	217,391						7
8	4 ton trane unit	2010	10,684						8
9	gutters	2010	15,000						9
10									10
11	Generator	2011	16,655						11
12	Rooftop A/C	2011	17,993						12
13	Laundry building roof	2011	3,905						13
14									14
15	Generator	2012	41,991						15
16	Sprinkler system	2012	134,928						16
17	Nurse Call System	2012	4,742						17
18									18
19	Sprinkler System - Final	2013	53,727						19
20	Lighting Retrofit	2013	3,132						20
21									21
22	Replace Boiler	2014	13,000						22
23	Install Refrigeration Equipment	2014	6,240						23
24	Cabling and Electrical - Point of Care Kiosks	2014	7,478						24
25	Install Rooftop AC Unit	2014	9,484						25
26	Replace Roof - 300 Wing	2014	191,507						26
27									27
28	Replace evaporator and condensor in walk-in freezer	2015	7,215						28
29	Replace (4) PTAC units	2015	2,813						29
30	Install new kitchen rooftop heating/cooling unit	2015	14,500						30
31	Installed new water storage tank	2015	4,636						31
32									32
33	No 2016 Improvements								33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,283,082	\$ 287,983		\$ 287,983	\$	\$	34

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

Facility Name & ID Number Heritage Manor Pana LLC

# 48884

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		\$ 6,283,082	\$ 287,983		\$ 287,983		\$
2							
3	2017	2,759					
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		\$ 6,285,841	\$ 287,983		\$ 287,983	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,040,275	\$ 30,973	\$ 30,973	\$		\$	71
72	Current Year Purchases	9,250						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,049,525	\$ 30,973	\$ 30,973	\$		\$	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		2007 Chevy Upland van	2012	\$ 13,988	\$ 1,998	\$ 1,998	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 13,988	\$ 1,998	\$ 1,998	\$		\$	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)	\$ 7,400,409	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 320,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 320,954	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: None

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 51,561 Description: Mattresses, televisions, CPM's office equipment

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		3,293		3,293
3	Classroom Wages (a)		3,603		3,603
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 6,896	\$	\$ 6,896
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	6,896		

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 690,890	\$		\$ 690,890	1
2	Licensed Speech and Language Development Therapist		hrs			153,049			153,049	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			558,004	3,970		561,974	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				764,097		764,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					72,142			72,142	13
14	TOTAL			\$		\$ 1,474,085	\$ 768,067		\$ 2,242,152	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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,149	\$	1
2	Cash-Patient Deposits	20,754		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,544,638		3
4	Supply Inventory (priced at <u>FIFO</u> )	10,255		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,652		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(512,352)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,068,096	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,068,096	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 112,664	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,754		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	448,701		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,603		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Bed Tax</u>	29,949		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 615,671	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 615,671	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 452,425	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,068,096	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>256,544</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>256,544</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>195,881</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>195,881</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>452,425</b>	<b>24</b> *

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

Facility Name &amp; ID Number Heritage Manor Pana LLC

# 48884

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,964,896	1
2	Discounts and Allowances for all Levels	(4,815,861)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,149,035	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,543,482	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,543,482	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,081	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,457,348	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,093	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,504,522	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,622	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,622	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,202,661	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,248,030	31
32	Health Care	3,689,762	32
33	General Administration	1,863,340	33
<b>B. Capital Expense</b>			
34	Ownership	780,996	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,424,652	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,006,780	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	195,881	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 195,881	43

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

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

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

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

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

Facility Name & ID Number Heritage Manor Pana LLC

# 48884

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	1,858	1,956	\$ 68,122	\$ 34.83	1
2	Assistant Director of Nursing	1,566	1,648	55,454	33.65	2
3	Registered Nurses	9,606	10,111	316,683	31.32	3
4	Licensed Practical Nurses	24,289	25,567	613,365	23.99	4
5	CNAs & Orderlies	98,483	103,667	1,319,206	12.73	5
6	CNA Trainees	404	425	3,603	8.48	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,498	6,841	144,520	21.13	8
9	Activity Director					9
10	Activity Assistants	4,414	4,646	58,938	12.69	10
11	Social Service Workers	3,064	3,225	53,419	16.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,774	22,920	272,857	11.90	15
16	Dishwashers					16
17	Maintenance Workers	4,781	5,033	115,910	23.03	17
18	Housekeepers	9,252	9,739	110,367	11.33	18
19	Laundry	5,054	5,320	60,623	11.40	19
20	Administrator	1,763	1,856	82,151	44.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,306	11,901	268,454	22.56	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)	204,112	214,855	\$ 3,543,672 *	\$ 16.49	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	17,000	36
37	Medical Records Consultant	12,960	37
38	Nurse Consultant		38
39	Pharmacist Consultant	6,899	39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant	3,202	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 40,061	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 Pana LLC# 48884Report 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. \$ 250,462  
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. \$ 1,880
- (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 - Pana  
IDPH ID# 48884  
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	\$	764,097
Purchased Hospital Services		19,050
Purchased Laboratory Services		41,219
Purchased Radiology Services		11,873
Amount Reclassified to Line 39	\$	<u>836,239</u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	70,080
Provider Assessment Fee - \$6.70		180,382
Amount Reclassified to Line 42		<u>250,462</u>