

Facility Name & ID Number Heritage Manor Peru LLC

48090 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	127	Skilled (SNF)	127	46,355	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	127	TOTALS	127	46,355	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	25,522	6,243	5,286	37,051	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,522	6,243	5,286	37,051	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.93%

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 7/2006

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 127 and days of care provided 5,286

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 Peru LLC # 48090 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	245,440	15,991		261,431		261,431	4,997	266,428		1
2	Food Purchase		268,080		268,080		268,080		268,080		2
3	Housekeeping	84,598	46,022		130,620		130,620	7	130,627		3
4	Laundry	67,206	10,476		77,682		77,682	1	77,683		4
5	Heat and Other Utilities			117,399	117,399		117,399	1,922	119,321		5
6	Maintenance	133,021	75,391	113,018	321,430		321,430	29,318	350,748		6
7	Other (specify):*										7
8	TOTAL General Services	530,265	415,960	230,417	1,176,642		1,176,642	36,245	1,212,887		8
	B. Health Care and Programs										
9	Medical Director			32,448	32,448		32,448		32,448		9
10	Nursing and Medical Records	2,751,406	218,858	7,821	2,978,085		2,978,085	(28,573)	2,949,512		10
10a	Therapy		819,846	38,111	857,957	(857,934)	23		23		10a
11	Activities	149,534	1,809		151,343		151,343		151,343		11
12	Social Services	56,409		3,229	59,638		59,638		59,638		12
13	CNA Training							1,379	1,379		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,957,349	1,040,513	81,609	4,079,471	(857,934)	3,221,537	(27,194)	3,194,343		16
	C. General Administration										
17	Administrative	91,962			91,962		91,962		91,962		17
18	Directors Fees										18
19	Professional Services			463,046	463,046		463,046	(439,583)	23,463		19
20	Dues, Fees, Subscriptions & Promotions			326,124	326,124	(266,602)	59,522	(31,123)	28,399		20
21	Clerical & General Office Expenses	340,106	28,182	44,160	412,448		412,448	460,519	872,967		21
22	Employee Benefits & Payroll Taxes			676,783	676,783		676,783	62,267	739,050		22
23	Inservice Training & Education			8,055	8,055		8,055	(3,124)	4,931		23
24	Travel and Seminar			5,762	5,762		5,762	(763)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			43,208	43,208		43,208	15,022	58,230		26
27	Other (specify):*			56,220	56,220		56,220	(56,220)			27
28	TOTAL General Administration	432,068	28,182	1,623,358	2,083,608	(266,602)	1,817,006	6,995	1,824,001		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,919,682	1,484,655	1,935,384	7,339,721	(1,124,536)	6,215,185	16,046	6,231,231		29

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

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

Facility Name & ID Number

Heritage Manor Peru LLC

#48090

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							307,516	307,516			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,122	65,122		65,122	108,415	173,537			32
33	Real Estate Taxes							54,500	54,500			33
34	Rent-Facility & Grounds			565,020	565,020		565,020	(557,362)	7,658			34
35	Rent-Equipment & Vehicles			25,852	25,852		25,852	9,784	35,636			35
36	Other (specify):*											36
37	TOTAL Ownership			655,994	655,994		655,994	(77,147)	578,847			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			940,505	940,505	857,934	1,798,439	(241,645)	1,556,794			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					266,602	266,602		266,602			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			940,505	940,505	1,124,536	2,065,041	(241,645)	1,823,396			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,919,682	1,484,655	3,531,883	8,936,220		8,936,220	(302,746)	8,633,474			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	(6,020)			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	(5,196)			17
18	Fines and Penalties				18
19	Entertainment	(11,209)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,661)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,220)			24
25	Fund Raising, Advertising and Promotional	(41,499)			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)	\$ (136,805)		\$	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)	(165,941)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (165,941)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (302,746)		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 Peru LLC

ID# 48090

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		(16,661)	19	22
23				23
24		(56,220)	27	24
25		(41,499)	20	25
26				26
27		0	29	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(114,380)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Peru LLC# 48090

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	4,997	0	0	0	0	0	0	0	0	4,997	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	1,922	0	0	0	0	0	0	0	0	1,922	5
6	Maintenance	0	0	29,318	0	0	0	0	0	0	0	0	29,318	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	36,245	0	0	0	0	0	0	0	0	36,245	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	(29,043)	470	0	0	0	0	0	0	0	0	(28,573)	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	1,379	0	0	0	0	0	0	0	0	1,379	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	(29,043)	1,849	0	0	0	0	0	0	0	0	(27,194)	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	(16,661)	(444,119)	21,197	0	0	0	0	0	0	0	0	(439,583)	19
20	Fees, Subscriptions & Promotions	(41,499)	0	10,376	0	0	0	0	0	0	0	0	(31,123)	20
21	Clerical & General Office Expenses	0	0	460,519	0	0	0	0	0	0	0	0	460,519	21
22	Employee Benefits & Payroll Taxes	0	0	62,267	0	0	0	0	0	0	0	0	62,267	22
23	Inservice Training & Education	(5,196)	(68)	2,140	0	0	0	0	0	0	0	0	(3,124)	23
24	Travel and Seminar	(11,209)	0	10,446	0	0	0	0	0	0	0	0	(763)	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	15,022	0	0	0	0	0	0	0	0	15,022	26
27	Other (specify):*	(56,220)	0	0	0	0	0	0	0	0	0	0	(56,220)	27
28	TOTAL General Administration	(130,785)	(444,187)	581,967	0	0	0	0	0	0	0	0	6,995	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(130,785)	(473,230)	620,061	0	0	0	0	0	0	0	0	16,046	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Peru LLC # 48090 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	269,663	0	37,853	0	0	0	0	0	0	0	307,516	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,020)	112,233	0	2,202	0	0	0	0	0	0	0	108,415	32
33	Real Estate Taxes	0	54,500	0	0	0	0	0	0	0	0	0	54,500	33
34	Rent-Facility & Grounds	0	(565,020)	0	7,658	0	0	0	0	0	0	0	(557,362)	34
35	Rent-Equipment & Vehicles	0	0	0	9,784	0	0	0	0	0	0	0	9,784	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,020)	(128,624)	0	57,497	0	(77,147)	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	(241,645)	0	0	0	0	0	0	0	0	0	(241,645)	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	(241,645)	0	0	0	0	0	0	0	0	0	(241,645)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(136,805)	(843,499)	620,061	57,497	0	(302,746)	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		\$(29,043)	\$(29,043)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(68)	(68)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(241,645)	(241,645)	3
4	V	19 Adjustment for Related Organization	444,119	Heritage Operations Group, LLC			(444,119)	4
5	V							5
6	V	34 Adjustment for Related Organization	565,020	Heritage Manor Real Estate, LLC			(565,020)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		54,500	54,500	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		101,753	101,753	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		269,663	269,663	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		10,480	10,480	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,009,139			\$ 165,640	\$ * (843,499)	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		\$	\$	4,997 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						1,922 19
20	V	6 Maintenance						29,318 20
21	V	7 Other						0 21
22	V	9 Medical Director						0 22
23	V	10 Nursing & Medical Records						470 23
24	V	11 Activities						0 24
25	V	12 Social Service						0 25
26	V	13 Nurse Aide Training						1,379 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						21,197 31
32	V	20 Fees, Subscription, Promotions						10,376 32
33	V	21 Clerical & General Office Expenses						460,519 33
34	V	22 Employee Benefits & Payroll Taxes						62,267 34
35	V	23 Inservice Training & Education						2,140 35
36	V	24 Travel and Seminar						10,446 36
37	V	25 Other Admin. Staff Transportation						0 37
38	V	26 Insurance-Prop.Liab.Malpract						15,022 38
39	Total		\$			\$	0	\$ * 620,061 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						37,853 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						2,202 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						7,658 20
21	V	35 Rent-Equipment & Vehicles						9,784 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	\$ * 57,497 39

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

Facility Name & ID Number Heritage Manor Peru LLC # 48090 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 Peru LLC

48090

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	127	\$ 4,997	1
2	2	Food Purchase	Beds	2,578	26	0	0	127	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	127	7	3
4	4	Laundry	Beds	2,578	26	16	0	127	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	127	1,922	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	127	29,318	6
7	7	Other	Beds	2,578	26	0	0	127	0	7
8	9	Medical Director	Beds	2,578	26	0	0	127	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	127	470	9
10	11	Activities	Beds	2,578	26	0	0	127	0	10
11	12	Social Service	Beds	2,578	26	0	0	127	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	127	1,379	12
13	14	Program Transportation	Beds	2,578	26	0	0	127	0	13
14	15	Other	Beds	2,578	26	0	0	127	0	14
15	17	Administrative	Beds	2,578	26	0	0	127	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	127	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	127	21,197	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	127	10,376	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	127	460,519	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	127	62,267	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	127	2,140	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	127	10,446	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	127	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	127	15,022	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 620,061	25

Facility Name & ID Number Heritage Manor Peru LLC

48090

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	\$	127	\$	1
2	30	Depreciation	Beds	2,578	26	768,393	127	37,853	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		127		3
4	32	Interest	Beds	2,578	26	44,696	127	2,202	4
5	33	Real Estate Taxes	Beds	2,578	26		127		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	127	7,658	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	127	9,784	7
8	36	Other	Beds	2,578	26		127		8
9	38	Medically Nec Transportation	Beds	2,578	26		127		9
10	39	Ancillary Service Centers	Beds	2,578	26		127		10
11	40	Barber and Beauty Shops	Beds	2,578	26		127		11
12	41	Coffee and Gift Shops	Beds	2,578	26		127		12
13	42	Other	Beds	2,578	26		127		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	\$	57,497	25

Facility Name & ID Number

Heritage Manor Peru LLC

48090

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		x	Mortgage			\$	\$		\$ 101,753	1									
2	Bank of America		x	Loan Fee Amortization						10,480	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						65,122	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 177,355	9									
B. Non-Facility Related*																				
10	Interest Income									(6,020)	10									
11											11									
12	Allocated Corporate									2,202	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (3,818)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 173,537	15									

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	54,500	2
3. Under or (over) accrual (line 2 minus line 1).		\$	54,500	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.		\$	54,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	47,738	8
	2013	48,642	9
	2014	49,486	10
	2015	50,571	11
	2016	54,500	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 Peru LLC COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 48090

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>1709312014</u>	_____	\$ <u>51,826.04</u>	\$ <u>51,826.00</u>
2. <u>1709312013</u>	_____	\$ <u>2,673.68</u>	\$ <u>2,674.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>54,499.72</u></u>	\$ <u><u>54,500.00</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 Peru LLC

48090

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,520 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: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 50,000, 1. Row 2: 2. Row 3: 3 TOTALS, 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	127			\$ 391,963	\$		\$	\$	\$
5				325,293					
6				153,474					
7				677,402					
8									
Improvement Type**									
9	1978 Improvements		1979	6,059					
10	1979 Improvements		1980	9,952					
11	1980 Improvements		1981	28,648					
12	1981 Improvements		1982	8,175					
13	1982 Improvements		1983	39,938					
14	1983 Improvements		1985	13,985					
15	1984 Improvements		1986	19,793					
16	1985 Improvements		1987	550					
17	1986 Improvements		1988	22,120					
18	1988 Improvements		1989	19,053					
19	1989 Improvements		1990	25,453					
20	1990 Improvements		1991	12,118					
21	1991 Improvements		1992	19,157					
22	1992 Improvements		1993	87,224					
23	1993 Improvements		1994	43,270					
24	1994 Improvements		1995	16,885					
25	1995 Improvements		1996	8,377					
26	WATER SOFTNER		1996	4,550					
27	AIR CONDITIONER			97					
28									
29									
30									
31									
32									
33	C/O Allocation				37,853		37,853		
34	Book Depreciation				226,780		226,780		
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 Peru LLC# 48090

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	Interior Rehab---	1997	\$ 292,864	\$		\$	\$	\$	37
38	Parking Lot Sealer	1997	3,100						38
39	Commercial Disposal	1997	877						39
40									40
41	Water Heater	1998	4,308						41
42	A/C Repair	1998	6,457						42
43	Heater Repair	1998	954						43
44	Laundry Room Remodel	1998	1,450						44
45	Interior Rehab	1998	7,466						45
46									46
47	GFI Outlets	1999	3,420						47
48	Water Meter	1999	1,854						48
49	Roof Replacements	1999	80,498						49
50									50
51	Water Main Break Repair	2000	5,272						51
52	Door Monitor System	2000	9,852						52
53	Patio Improvements	2000	1,310						53
54									54
55	Lennox Condenser	2001	4,527						55
56	Water Heater	2001	3,708						56
57	Sewer Repair	2001	932						57
58									58
59	Sewer Repair	2002	1,267						59
60	Water Heater	2002	4,340						60
61	Ceiling Tiles	2002	110						61
62	Seal Parking Lot	2002	3,100						62
63	Door Lock	2002	1,370						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,372,572	\$ 264,633		\$ 264,633	\$	\$	70

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

Facility Name & ID Number Heritage Manor Peru LLC

48090

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		\$ 2,372,572	\$ 264,633		\$ 264,633	\$	\$	1
2	Compressor	2003	844						2
3	Shower Room Remodel	2003	4,916						3
4	Back Flow Valve	2003	1,241						4
5	Parking Lot	2003	3,100						5
6	Generator	2003	2,749						6
7	Compressor	2003	939						7
8									8
9									9
10									10
11	Wallguards	2004	22,275						11
12									12
13	Carpet		7,174						13
14									14
15	Ansul System	2005	1,685						15
16	Heat Exchanger	2005	1,800						16
17	Wall hvac	2005	959						17
18	Wallguards	2005	2,313						18
19	A/C condensing unit	2005	4,078						19
20	Exterior Door	2005	17,485						20
21	Solarium	2005	3,812						21
22	Lennox	2005	5,950						22
23	Shower Room Remodel	2005	5,588						23
24	Window Replacement	2005	55,419						24
25	Parking Lot Sealer	2005	3,940						25
26	Disposal	2005	1,303						26
27	Courtyard Door	2005	1,354						27
28	various adjustments	2005	(22,516)						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,498,980	\$ 264,633		\$ 264,633	\$	\$	34

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

Facility Name & ID Number Heritage Manor Peru LLC

48090

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,498,980	\$ 264,633		\$ 264,633	\$	\$	1
2	Code Alert	2006	7,226						2
3	Windows	2006	876						3
4	Exterior Door	2006	2,620						4
5	Chimney	2006	6,250						5
6	Boiler	2006	3,002						6
7	Garbage Disposal	2006	1,072						7
8	Sprinklers	2006	34,076						8
9	Heat Pump	2006	1,073						9
10	2006 adj	2006	(918)						10
11	Sprinkler System	2007	189,741						11
12	Water Heater	2007	11,400						12
13	Sewer	2007	3,394						13
14	HVAC	2007	70,422						14
15	Gazebo	2007	4,750						15
16	PTAC Unit	2007	2,720						16
17	Wander Guard	2007	3,129						17
18	2007 adj	2007	(12,899)						18
19	Condensor	2007	14,138						19
20	2008 adj	2008	(8,200)						20
21	Water Main	2008	30,831						21
22	Resident Room Plumbing	2008	12,661						22
23	Parking Lot Repairs	2008	5,221						23
24	Water Softener	2008	9,748						24
25	Water Heater	2008	9,120						25
26	Nurse Call & Phone system	2009	217,290						26
27	Water Pipe	2009	16,750						27
28	Condensing Unit	2009	3,334						28
29									29
30	Plumbing	2009	4,295						30
31	Concrete Ramp	2009	3,150						31
32	Water Heater	2009	6,750						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,152,002	\$ 264,633		\$ 264,633	\$	\$	34

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

Facility Name & ID Number Heritage Manor Peru LLC

48090

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,152,002	\$ 264,633		\$ 264,633	\$	\$	1
2	The following items relate to the rehab of all wings, resident rooms and central								2
3	common area spaces performed by DS Renovations, LLC								3
4	General Conditions & Demolition	2009	89,600						4
5	Carpentry & Millwork	2009	251,225						5
6	Acoustical Ceiling & Flooring	2009	150,757						6
7	Painting	2009	56,514						7
8	Plumbing	2009	30,679						8
9	Electrical	2009	88,804						9
10	HVAC	2009	43,648						10
11	Overhead & Profit	2009	31,594						11
12									12
13	Environmental & Engineering	2009	12,958						13
14									14
15	Exhaust Fan	2010	12,795						15
16	Landscaping	2010	31,701						16
17	Parking Lot	2010	46,950						17
18	DS Renovations, LLC								18
19	General Conditions & Demolition	2010	41,507						19
20	Carpentry & Millwork	2010	77,921						20
21	Acoustical Ceiling & Flooring	2010	29,947						21
22	Painting	2010	75,786						22
23	Plumbing	2010	27,465						23
24	Electrical	2010	42,154						24
25	HVAC	2010	21,347						25
26	Overhead & Profit	2010	16,506						26
27	Contingency & change orders	2010	45,238						27
28									28
29	Interior Design - Renovation Project	2010	6,000						29
30	Plaster/window/shelving (PMSI Construction)	2010	19,170						30
31	Asbestos Abatement	2010	189,525						31
32	Direct supply Window treatments, bed spreads	2010	38,949						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,630,742	\$ 264,633		\$ 264,633	\$	\$	34

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

Facility Name & ID Number Heritage Manor Peru LLC

48090

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 12D, Carried Forward		\$ 4,630,742	\$ 264,633		\$ 264,633	\$	\$	1
2									2
3	Exterior Lights	2011	7,955						3
4	In-sink-erator	2010	2,675						4
5	Air Handler	2011	20,385						5
6	Sign	2011	2,600						6
7	Fire Alarm	2011	8,665						7
8									8
9	Fire Alarm	2012	2,600						9
10	Sprinkler Head	2012	3,464						10
11	Lighting Retrofit	2012	3,255						11
12	Boilers	2012	8,190						12
13									13
14	Condensing Unit	2013	28,841						14
15	Roof Replacement	2013	152,428						15
16									16
17	Purchase New Air Compressor	2014	2,850						17
18	New Water Heater	2014	7,980						18
19	Parking Lot Resurfacing	2014	4,687						19
20	Replace Boiler	2014	16,814						20
21	Replace Condenser	2014	3,092						21
22	Wiring and Cabling for Point of Care Kiosks	2014	12,437						22
23									23
24	Circuit and wire installation for wall mounted heaters	2015	5,820						24
25	New air condensing unit - middle hallway	2015	4,628						25
26	New air handler (5 ton) - entry way	2015	5,387						26
27	Replace sewer line	2015	37,614						27
28	Radiator replacement	2015	3,624						28
29	Install 100 gallon water heater	2015	7,980						29
30	Replace sewer pipe and foundation wall	2015	6,580						30
31	Cabling - 30 Cat 6 to data room	2015	15,610						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,006,903	\$ 264,633		\$ 264,633	\$	\$	34

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

Facility Name & ID Number Heritage Manor Peru LLC

48090

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 12E, Carried Forward		\$ 5,006,903	\$ 264,633		\$ 264,633	\$	\$	1
2									2
3	Install hot water storage tank	2016	10,291						3
4	Replace fire alarm wiring	2016	3,984						4
5	Repair sewer and concrete walkway	2016	9,798						5
6									6
7	Added (2) water cabinet heaters to therapy room and (9)	2017	29,286						7
8	cabinet heaters to various hallways throughout the facility								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
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,060,262	\$ 264,633		\$ 264,633	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,670,322	\$ 42,883	\$ 42,883	\$		\$	71
72	Current Year Purchases	12,671						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,682,993	\$ 42,883	\$ 42,883	\$		\$	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)	\$ 6,793,255	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 307,516	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 307,516	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 Peru LLC

48090

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: \$ 25,852 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	<u>None</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 469,017	\$		\$ 469,017	1
2	Licensed Speech and Language Development Therapist		hrs			50,258			50,258	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			421,230	23		421,253	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				819,823		819,823	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					38,111			38,111	13
14	TOTAL			\$		\$ 978,616	\$ 819,846		\$ 1,798,462	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.

Facility Name & ID Number Heritage Manor Peru LLC

48090

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

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	\$ 513	\$	1
2	Cash-Patient Deposits	33,225		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,590,874		3
4	Supply Inventory (priced at FIFO)	13,788		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,884		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(952,219)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 691,065	\$	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)	\$ 691,065	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 107,658	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,225		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	422,090		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,218		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>	31,546		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 596,737	\$	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)	\$ 596,737	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 94,328	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 691,065	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (106,520)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (106,520)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	200,848	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)	\$ 200,848	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)	\$ 94,328	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor Peru LLC

48090

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**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,280,170	1
2	Discounts and Allowances for all Levels	(3,593,699)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,686,471	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,866,830	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,866,830	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,576,670	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,077	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,577,747	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,020	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,020	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,137,068	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,176,642	31
32	Health Care	4,079,471	32
33	General Administration	2,083,608	33
B. Capital Expense			
34	Ownership	655,994	34
C. Ancillary Expense			
35	Special Cost Centers	940,505	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)*	\$ 8,936,220	40
41	Income before Income Taxes (line 30 minus line 40)**	200,848	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 200,848	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 Peru LLC

48090

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	1,733	1,824	\$ 73,251	\$ 40.16	1
2	Assistant Director of Nursing	1,383	1,456	46,607	32.01	2
3	Registered Nurses	24,841	26,149	822,653	31.46	3
4	Licensed Practical Nurses	15,008	15,798	410,229	25.97	4
5	CNAs & Orderlies	84,606	89,059	1,324,031	14.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,547	2,681	74,635	27.84	8
9	Activity Director					9
10	Activity Assistants	7,930	8,347	149,534	17.91	10
11	Social Service Workers	2,781	2,927	56,409	19.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,273	19,234	245,440	12.76	15
16	Dishwashers					16
17	Maintenance Workers	7,460	7,853	133,021	16.94	17
18	Housekeepers	7,086	7,459	84,598	11.34	18
19	Laundry	6,780	7,137	67,206	9.42	19
20	Administrator	1,756	1,848	91,962	49.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,772	13,444	340,106	25.30	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)	194,956	205,216	\$ 3,919,682 *	\$ 19.10	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	32,448		36
37	Medical Records Consultant	910		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,911		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	3,229		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 43,498		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 Peru LLC# 48090Report 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. \$ 266,602
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. \$ 5
- (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 - Peru
HFS ID# 48090
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	\$	819,823
Purchased Hospital Services		21,307
Purchased Laboratory Services		9,759
Purchased Radiology Services		<u>7,045</u>
Amount Reclassified to Line 39	\$	<u><u>857,934</u></u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	69,533
Provider Assessment Fee - \$6.70		<u>197,069</u>
Amount Reclassified to Line 42		<u><u>266,602</u></u>