

Facility Name & ID Number Heritage Manor Gillespie LLC

48900 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,959	9,121	2,342	22,422	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,959	9,121	2,342	22,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.43%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 7/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 100 and days of care provided 2,342

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor Gillespie LLC # 48900 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	184,051	11,863	6,110	202,024		202,024	4,036	206,060		1
2	Food Purchase		164,587		164,587		164,587	53	164,640		2
3	Housekeeping	110,544	20,149		130,693		130,693		130,693		3
4	Laundry	53,685	12,697		66,382		66,382	4	66,386		4
5	Heat and Other Utilities			83,734	83,734		83,734	1,465	85,199		5
6	Maintenance	38,415	43,224	67,406	149,045		149,045	22,152	171,197		6
7	Other (specify):*										7
8	TOTAL General Services	386,695	252,520	157,250	796,465		796,465	27,710	824,175		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,380,963	91,659	7,622	1,480,244		1,480,244	(21,458)	1,458,786		10
10a	Therapy		207,813	74,863	282,676	(282,676)					10a
11	Activities	45,240	3,657		48,897		48,897		48,897		11
12	Social Services	43,551		1,115	44,666		44,666		44,666		12
13	CNA Training							1,160	1,160		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,469,754	303,129	101,600	1,874,483	(282,676)	1,591,807	(20,298)	1,571,509		16
	C. General Administration										
17	Administrative	82,436			82,436		82,436		82,436		17
18	Directors Fees										18
19	Professional Services			238,048	238,048		238,048	(219,602)	18,446		19
20	Dues, Fees, Subscriptions & Promotions			194,053	194,053	(172,296)	21,757	(779)	20,978		20
21	Clerical & General Office Expenses	163,888	25,489	12,593	201,970		201,970	354,563	556,533		21
22	Employee Benefits & Payroll Taxes			379,536	379,536		379,536	46,247	425,783		22
23	Inservice Training & Education			4,037	4,037		4,037	962	4,999		23
24	Travel and Seminar			1,562	1,562		1,562	3,437	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,062	39,062		39,062	24,940	64,002		26
27	Other (specify):* Lost items - residents			32,305	32,305		32,305	(31,948)	357		27
28	TOTAL General Administration	246,324	25,489	901,196	1,173,009	(172,296)	1,000,713	177,820	1,178,533		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,102,773	581,138	1,160,046	3,843,957	(454,972)	3,388,985	185,232	3,574,217		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							215,706	215,706			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,173	58,173		58,173	115,518	173,691			32
33	Real Estate Taxes							29,742	29,742			33
34	Rent-Facility & Grounds			516,840	516,840		516,840	(510,706)	6,134			34
35	Rent-Equipment & Vehicles			15,132	15,132		15,132	6,211	21,343			35
36	Other (specify):*											36
37	TOTAL Ownership			590,145	590,145		590,145	(143,529)	446,616			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			541,371	541,371	282,676	824,047	146,930	970,977			39
40	Barber and Beauty Shops		1,132	18,552	19,684		19,684		19,684			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					172,296	172,296		172,296			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,132	559,923	561,055	454,972	1,016,027	146,930	1,162,957			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,102,773	582,270	2,310,114	4,995,157		4,995,157	188,633	5,183,790			45

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	(11,763)			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	(667)			17
18	Fines and Penalties				18
19	Entertainment	(4,002)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,323)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,948)			24
25	Fund Raising, Advertising and Promotional	(10,436)			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)	\$ (63,139)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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)	251,772		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 251,772		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 188,633		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

Heritage Manor Gillespie LLC

ID# 48900

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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		0	30	22
23		(4,323)	19	23
24		(31,948)	27	24
25		(10,436)	20	25
26		(4,002)	24	26
27		0	27	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	(50,709)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Gillespie LLC# 48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,036	0	0	0	0	0	0	0	0	4,036	1
2	Food Purchase	0	0	53	0	0	0	0	0	0	0	0	53	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	4	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	1,465	0	0	0	0	0	0	0	0	1,465	5
6	Maintenance	0	0	22,152	0	0	0	0	0	0	0	0	22,152	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,710	0	0	0	0	0	0	0	0	27,710	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	(22,104)	646	0	0	0	0	0	0	0	0	(21,458)	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	1,160	0	0	0	0	0	0	0	0	1,160	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	(22,104)	1,806	0	0	0	0	0	0	0	0	(20,298)	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	(4,323)	(232,390)	17,111	0	0	0	0	0	0	0	0	(219,602)	19
20	Fees, Subscriptions & Promotions	(10,436)	0	9,657	0	0	0	0	0	0	0	0	(779)	20
21	Clerical & General Office Expenses	0	0	354,563	0	0	0	0	0	0	0	0	354,563	21
22	Employee Benefits & Payroll Taxes	0	0	46,247	0	0	0	0	0	0	0	0	46,247	22
23	Inservice Training & Education	(667)	(108)	1,737	0	0	0	0	0	0	0	0	962	23
24	Travel and Seminar	(4,002)	0	7,439	0	0	0	0	0	0	0	0	3,437	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	24,940	0	0	0	0	0	0	0	0	24,940	26
27	Other (specify):*	(31,948)	0	0	0	0	0	0	0	0	0	0	(31,948)	27
28	TOTAL General Administration	(51,376)	(232,498)	461,694	0	0	0	0	0	0	0	0	177,820	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,376)	(254,602)	491,210	0	0	0	0	0	0	0	0	185,232	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	187,480	0	28,226	0	0	0	0	0	0	0	215,706	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,763)	127,281	0	0	0	0	0	0	0	0	0	115,518	32
33	Real Estate Taxes	0	29,742	0	0	0	0	0	0	0	0	0	29,742	33
34	Rent-Facility & Grounds	0	(516,840)	0	6,134	0	0	0	0	0	0	0	(510,706)	34
35	Rent-Equipment & Vehicles	0	0	0	6,211	0	0	0	0	0	0	0	6,211	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,763)	(172,337)	0	40,571	0	(143,529)	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	146,930	0	0	0	0	0	0	0	0	0	146,930	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	146,930	0	0	0	0	0	0	0	0	0	146,930	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(63,139)	(280,009)	491,210	40,571	0	188,633	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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attached Following This Page</u>		<u>Heritage Operations G</u>	<u>Bloomington</u>	<u>Mgmt. Services</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</u>

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>10 Adjustment for Related Organization</u>	\$	<u>GreenTree Pharmacy</u>		\$ <u>(22,104)</u>	\$	<u>(22,104)</u> 1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>(108)</u>		<u>(108)</u> 2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>146,930</u>		<u>146,930</u> 3
4	V	<u>19 Adjustment for Related Organization</u>	<u>232,390</u>	<u>Heritage Operations Group, LLC</u>				<u>(232,390)</u> 4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>516,840</u>	<u>Heritage Manor Real Estate, LLC</u>				<u>(516,840)</u> 6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>29,742</u>		<u>29,742</u> 7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>126,957</u>		<u>126,957</u> 8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>187,480</u>		<u>187,480</u> 9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>324</u>		<u>324</u> 10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>749,230</u>			\$ <u>469,221</u>	\$ *	<u>(280,009)</u> 14

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

Facility Name & ID Number

Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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		\$	\$ 4,036	15
16	V	2 Food Purchase		Heritage Operations Group			53	16
17	V	3 Housekeeping		Heritage Operations Group			0	17
18	V	4 Laundry		Heritage Operations Group			4	18
19	V	5 Heat & Other Utilities		Heritage Operations Group			1,465	19
20	V	6 Maintenance		Heritage Operations Group			22,152	20
21	V	7 Other		Heritage Operations Group			0	21
22	V	9 Medical Director		Heritage Operations Group			0	22
23	V	10 Nursing & Medical Records		Heritage Operations Group			646	23
24	V	11 Activities		Heritage Operations Group			0	24
25	V	12 Social Service		Heritage Operations Group			0	25
26	V	13 Nurse Aide Training		Heritage Operations Group			1,160	26
27	V	14 Program Transportation		Heritage Operations Group			0	27
28	V	15 Other		Heritage Operations Group			0	28
29	V	17 Administrative		Heritage Operations Group			0	29
30	V	18 Directors Fees		Heritage Operations Group			0	30
31	V	19 Professional Services		Heritage Operations Group			17,111	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			9,657	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			354,563	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			46,247	34
35	V	23 Inservice Training & Education		Heritage Operations Group			1,737	35
36	V	24 Travel and Seminar		Heritage Operations Group			7,439	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			24,940	38
39	Total		\$			\$	0	\$ * 491,210 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		Heritage Operations Group			28,226	16
17	V	31 Amortization of Pre-Op & Org		Heritage Operations Group			0	17
18	V	32 Interest		Heritage Operations Group			0	18
19	V	33 Real Estate Taxes		Heritage Operations Group			0	19
20	V	34 Rent-Facility & Grounds		Heritage Operations Group			6,134	20
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			6,211	21
22	V	36 Other		Heritage Operations Group			0	22
23	V	38 Medically Nec Transportation		Heritage Operations Group			0	23
24	V	39 Ancillary Service Centers		Heritage Operations Group			0	24
25	V	40 Barber and Beauty Shops		Heritage Operations Group			0	25
26	V	41 Coffee and Gift Shops		Heritage Operations Group			0	26
27	V	42 Other		Heritage Operations Group			0	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ * 40,571 39

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

Facility Name & ID Number

Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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.			100.00					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor Gillespie LLC # 48900 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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	\$ 104,045	\$ 103,180	100	\$ 4,036	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	100	53	2
3	3	Housekeeping	Beds	2,578	26	0	0	100	0	3
4	4	Laundry	Beds	2,578	26	111	0	100	4	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	100	1,465	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	100	22,152	6
7	7	Other	Beds	2,578	26	0	0	100	0	7
8	9	Medical Director	Beds	2,578	26	0	0	100	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	16,650	12,036	100	646	9
10	11	Activities	Beds	2,578	26	0	0	100	0	10
11	12	Social Service	Beds	2,578	26	0	0	100	0	11
12	13	Nurse Aide Training	Beds	2,578	26	29,896	28,423	100	1,160	12
13	14	Program Transportation	Beds	2,578	26	0	0	100	0	13
14	15	Other	Beds	2,578	26	0	0	100	0	14
15	17	Administrative	Beds	2,578	26	0	0	100	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	100	0	16
17	19	Professional Services	Beds	2,578	26	441,112	0	100	17,111	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	100	9,657	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	100	354,563	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	100	46,247	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	100	1,737	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	100	7,439	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	100	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	100	24,940	24
25	TOTALS					\$ 12,663,368	\$ 8,998,151		\$ 491,210	25

Facility Name & ID Number Heritage Manor Gillespie LLC # 48900 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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	\$	100	\$	1
2	30	Depreciation	Beds	2,578	26	727,658	100	28,226	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		100		3
4	32	Interest	Beds	2,578	26		100		4
5	33	Real Estate Taxes	Beds	2,578	26		100		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134	100	6,134	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109	100	6,211	7
8	36	Other	Beds	2,578	26		100		8
9	38	Medically Nec Transportation	Beds	2,578	26		100		9
10	39	Ancillary Service Centers	Beds	2,578	26		100		10
11	40	Barber and Beauty Shops	Beds	2,578	26		100		11
12	41	Coffee and Gift Shops	Beds	2,578	26		100		12
13	42	Other	Beds	2,578	26		100		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,045,901	\$		\$ 40,571	25

Facility Name & ID Number

Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Busey Bank		x	Mortgage			\$	\$		\$ 126,957	1									
2	Busey Bank		x	Loan Fee Amortization						324	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Busey Bank		x	Working Capital						58,173	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 185,454	9									
B. Non-Facility Related*																				
10	Interest Income									(11,763)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (11,763)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 173,691	15									

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

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

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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 2017 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	29,742	2
3. Under or (over) accrual (line 2 minus line 1).		\$	29,742	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	29,742	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	30,748	8	
	2014	30,528	9	
	2015	30,540	10	
	2016	29,998	11	
	2017	29,742	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>27,045</u>	1
2					2
3	TOTALS			\$ <u>27,045</u>	3

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100			\$ 3,578,055	\$		\$	\$	\$	
5										
6										
7										
8										
Improvement Type**										
9	1997 Improvements		1997	9,047						
10	1998 Improvements		1998	91,134						
11	1999 Improvements		1999	42,987						
12	2000 Improvements		2000	3,923						
13	2001 Improvements		2001	1,965						
14	2002 Improvements		2002	2,703						
15	2003 Improvements		2003	12,731						
16	2004 Improvements		2004	8,415						
17	2005 Improvements		2005	56,136						
18	2006 Improvements		2006	23,475						
19	2007 Improvements		2007	23,853						
20	2008 Improvements		2008	487,552						
21	2009 Improvements		2009	137,743						
22	2010 Improvements		2010	13,180						
23	2011 Improvements		2011	66,364						
24	2012 Improvements		2012	54,202						
25										
26	Front Parking Lot Paving		2013	53,996						
27	Water Heater		2013	6,750						
28	PTAC Units		2013	4,089						
29										
30										
31										
32										
33										
34	C/O Allocation				28,226		28,226			
35	Book Depreciation				164,341		164,341			
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

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			\$	\$		\$	\$	\$	37
38	Replace 6 PTAC Units	2014	6,686						38
39	Remove and Rebuild Exterior Wall	2014	8,583						39
40	Parking Lot Fill, Seal and Striping	2014	4,386						40
41									41
42	Install (6) new PTAC units	2015	9,604						42
43	Replacement of air conditioning unit - therapy	2015	6,035						43
44	Install bath, shower and wall tile - bathing room	2015	6,833						44
45									45
46	Install new 100 gallon water heater	2016	5,200						46
47									47
48	AC System installation - Laundry	2017	3,591						48
49	Removed carpet and replace with tile flooring in	2017	15,129						49
50	rooms damaged by flooding; removed and replaced damaged drywall								50
51									51
52	Install new PTAC	2018	4,659						52
53	Replace water heater	2018	7,755						53
54	Furnace reconstruction	2018	2,945						54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,759,706	\$ 192,567		\$ 192,567	\$	\$	70

**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	\$ 979,268	\$ 23,139	\$ 23,139	\$		\$	71
72	Current Year Purchases	28,468						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,007,736	\$ 23,139	\$ 23,139	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Turtle Top Van	2006	\$ 28,611	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 28,611	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,823,098	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 215,706	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 215,706	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.	<u> </u>	<u>/2019</u>	\$ <u> </u>
13.	<u> </u>	<u>/2020</u>	\$ <u> </u>
14.	<u> </u>	<u>/2021</u>	\$ <u> </u>

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: \$ 15,132 Description: Televisions and office machines

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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	\$		\$ 341,738	\$		\$ 341,738	1
2	Licensed Speech and Language Development Therapist		hrs			43,972			43,972	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			155,661	0		155,661	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				207,813		207,813	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					74,863			74,863	13
14	TOTAL			\$		\$ 616,234	\$ 207,813		\$ 824,047	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 Gillespie LLC

48900

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 402	\$	1
2	Cash-Patient Deposits	30,496		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	485,495		3
4	Supply Inventory (priced at <u>FIFO</u>)	11,728		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,409		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(104,091)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 425,439	\$	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)	\$ 425,439	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 98,999	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,496		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	318,925		30
31	Accrued Taxes Payable (excluding real estate taxes)	319		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>	10,295		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 459,034	\$	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)	\$ 459,034	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (33,595)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 425,439	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 152,507	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 152,507	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(186,102)	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)	\$ (186,102)	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)	\$ (33,595)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,482,411	1
2	Discounts and Allowances for all Levels	(1,430,228)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,052,183	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,350,775	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,350,775	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	10,118	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	382,243	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,848	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 394,209	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,763	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,763	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	125	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 125	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,809,055	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	796,465	31
32	Health Care	1,874,483	32
33	General Administration	1,173,009	33
B. Capital Expense			
34	Ownership	590,145	34
C. Ancillary Expense			
35	Special Cost Centers	561,055	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)*	\$ 4,995,157	40
41	Income before Income Taxes (line 30 minus line 40)**	(186,102)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (186,102)	43

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

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

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

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

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

Facility Name & ID Number **Heritage Manor Gillespie LLC**

48900

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	1,451	1,544	\$ 53,992	\$ 34.97	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	2,160	2,298	70,443	30.65	3
4	Licensed Practical Nurses	18,898	20,104	481,316	23.94	4
5	CNAs & Orderlies	43,348	46,115	719,477	15.60	5
6	CNA Trainees	8	9	0	0.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,826	1,943	55,735	28.69	8
9	Activity Director					9
10	Activity Assistants	3,389	3,605	45,240	12.55	10
11	Social Service Workers	1,823	1,939	43,551	22.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,588	15,519	184,051	11.86	15
16	Dishwashers					16
17	Maintenance Workers	2,004	2,132	38,415	18.02	17
18	Housekeepers	9,226	9,815	110,544	11.26	18
19	Laundry	3,754	3,993	53,685	13.44	19
20	Administrator	1,955	2,080	82,436	39.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,015	6,399	163,888	25.61	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)	110,445	117,495	\$ 2,102,773 *	\$ 17.90	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	\$ 6,110		35
36	Medical Director	18,000		36
37	Medical Records Consultant	796		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,037		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,115		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 30,058		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kim Schardan			\$ 82,436	Workers' Compensation Insurance	\$ 23,478	IDPH License Fee	\$	
				Unemployment Compensation Insurance	11,626	Advertising: Employee Recruitment	4,150	
				FICA Taxes	160,862	Health Care Worker Background Check (Indicate # of checks performed _____)	1,895	
				Employee Health Insurance	165,474	Patient Background Checks		
				Employee Meals		PR	7,199	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,457	
				Other Benefits	18,096	License & Fees	2,519	
				Central Office Allocation	46,247	Central Office Allocation	9,657	
						Less: Public Relations Expense	(7,199)	
						Non-allowable advertising	(2,700)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,436	TOTAL (agree to Schedule V, line 22, col.8)	\$ 425,783	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,978	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
								1,334
								0
							Seminar Expense	228
								3,437
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Operations Group	Management		\$ 233,725					
Legal adj to Zero			4,323					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 238,048					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor Gillespie LLC

48900

Report Period Beginning:

1/1/2018

Ending: 12/31/2018

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. Health Care Council of Illinois
- (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. \$ 172,296
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,252
- (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: May Cocagne & King
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor - Gillespie
IDPH ID# 48900
HFS Cost Report - December31, 2018
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 207,813
Purchased Hospital Services	64,891
Purchased Laboratory Services	5,027
Purchased Radiology Services	4,945
Amount Reclassified to Line 39	<u>\$ 282,676</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (54,750)
Provider Assesment Fee - \$6.07	<u>(117,546)</u>
	<u>(172,296)</u>
Provider Participation Fee - Line 42	<u>172,296</u>