



Facility Name & ID Number Heritage Manor Staunton LLC

# 48876 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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	11,489	8,737	2,578	22,804	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,489	8,737	2,578	22,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.42%

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 90 and days of care provided 2,578

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL  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 Staunton LLC # 48876 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
	<b>A. General Services</b>										
1	Dietary	167,638	15,379	6,056	189,073		189,073	3,632	192,705		1
2	Food Purchase		157,683		157,683		157,683	48	157,731		2
3	Housekeeping	108,475	25,017		133,492		133,492		133,492		3
4	Laundry	37,811	13,036		50,847		50,847	4	50,851		4
5	Heat and Other Utilities			80,323	80,323		80,323	1,319	81,642		5
6	Maintenance	59,744	51,809	68,617	180,170		180,170	19,936	200,106		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	373,668	262,924	154,996	791,588		791,588	24,939	816,527		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,722	19,722		19,722		19,722		9
10	Nursing and Medical Records	1,367,654	96,135	148,485	1,612,274		1,612,274	(14,252)	1,598,022		10
10a	Therapy		185,489	22,533	208,022	(207,344)	678		678		10a
11	Activities	39,349	5,433		44,782		44,782		44,782		11
12	Social Services	41,744		2,737	44,481		44,481		44,481		12
13	CNA Training	8,731	4,059		12,790		12,790	1,044	13,834		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,457,478	291,116	193,477	1,942,071	(207,344)	1,734,727	(13,208)	1,721,519		16
	<b>C. General Administration</b>										
17	Administrative	89,476			89,476		89,476		89,476		17
18	Directors Fees										18
19	Professional Services			407,036	407,036		407,036	(390,258)	16,778		19
20	Dues, Fees, Subscriptions & Promotions			194,807	194,807	(169,953)	24,854	(4,447)	20,407		20
21	Clerical & General Office Expenses	148,916	25,156	8,088	182,160		182,160	319,107	501,267		21
22	Employee Benefits & Payroll Taxes			352,215	352,215		352,215	41,622	393,837		22
23	Inservice Training & Education			3,180	3,180		3,180	1,527	4,707		23
24	Travel and Seminar			3,745	3,745		3,745	1,254	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,305	34,305		34,305	22,446	56,751		26
27	Other (specify):* <b>Lost items - residents</b>			61,906	61,906		61,906	(61,873)	33		27
28	<b>TOTAL General Administration</b>	238,392	25,156	1,065,282	1,328,830	(169,953)	1,158,877	(70,622)	1,088,255		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,069,538	579,196	1,413,755	4,062,489	(377,297)	3,685,192	(58,891)	3,626,301		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							178,753	178,753			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,356	52,356		52,356	209,739	262,095			32
33	Real Estate Taxes							34,235	34,235			33
34	Rent-Facility & Grounds			433,620	433,620		433,620	(428,099)	5,521			34
35	Rent-Equipment & Vehicles			15,117	15,117		15,117	5,590	20,707			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			501,093	501,093		501,093	218	501,311			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			476,341	476,341	207,344	683,685	(153,947)	529,738			39
40	Barber and Beauty Shops		952	10,557	11,509		11,509		11,509			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					169,953	169,953		169,953			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		952	486,898	487,850	377,297	865,147	(153,947)	711,200			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,069,538	580,148	2,401,746	5,051,432		5,051,432	(212,620)	4,838,812			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 Staunton LLC

# 48876

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	(3,563)			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				17
18	Fines and Penalties	(46,681)			18
19	Entertainment	(5,441)			19
20	Contributions	(100)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(160,762)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,092)			24
25	Fund Raising, Advertising and Promotional	(13,138)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (244,777)		\$	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)	32,157		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 32,157		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (212,620)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Heritage Manor Staunton LLC

ID# 48876

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		(160,762)	19	23
24		(15,092)	27	24
25		(13,138)	20	25
26		(5,441)	24	26
27		(46,781)	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	<b>Total</b>	(241,214)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Staunton LLC# 48876

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	3,632	0	0	0	0	0	0	0	0	3,632	1
2	Food Purchase	0	0	48	0	0	0	0	0	0	0	0	48	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	1,319	0	0	0	0	0	0	0	0	1,319	5
6	Maintenance	0	0	19,936	0	0	0	0	0	0	0	0	19,936	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	24,939	0	0	0	0	0	0	0	0	24,939	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(14,833)	581	0	0	0	0	0	0	0	0	(14,252)	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	1,044	0	0	0	0	0	0	0	0	1,044	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	(14,833)	1,625	0	0	0	0	0	0	0	0	(13,208)	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(160,762)	(244,896)	15,400	0	0	0	0	0	0	0	0	(390,258)	19
20	Fees, Subscriptions & Promotions	(13,138)	0	8,691	0	0	0	0	0	0	0	0	(4,447)	20
21	Clerical & General Office Expenses	0	0	319,107	0	0	0	0	0	0	0	0	319,107	21
22	Employee Benefits & Payroll Taxes	0	0	41,622	0	0	0	0	0	0	0	0	41,622	22
23	Inservice Training & Education	0	(36)	1,563	0	0	0	0	0	0	0	0	1,527	23
24	Travel and Seminar	(5,441)	0	6,695	0	0	0	0	0	0	0	0	1,254	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	22,446	0	0	0	0	0	0	0	0	22,446	26
27	Other (specify):*	(61,873)	0	0	0	0	0	0	0	0	0	0	(61,873)	27
28	<b>TOTAL General Administration</b>	(241,214)	(244,932)	415,524	0	0	0	0	0	0	0	0	(70,622)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(241,214)	(259,765)	442,088	0	0	0	0	0	0	0	0	(58,891)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Staunton LLC# 48876

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	153,350	0	25,403	0	0	0	0	0	0	0	178,753	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,563)	213,302	0	0	0	0	0	0	0	0	0	209,739	32
33	Real Estate Taxes	0	34,235	0	0	0	0	0	0	0	0	0	34,235	33
34	Rent-Facility & Grounds	0	(433,620)	0	5,521	0	0	0	0	0	0	0	(428,099)	34
35	Rent-Equipment & Vehicles	0	0	0	5,590	0	0	0	0	0	0	0	5,590	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,563)</b>	<b>(32,733)</b>	<b>0</b>	<b>36,514</b>	<b>0</b>	<b>218</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(153,947)	0	0	0	0	0	0	0	0	0	(153,947)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>(153,947)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(153,947)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(244,777)</b>	<b>(446,445)</b>	<b>442,088</b>	<b>36,514</b>	<b>0</b>	<b>(212,620)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<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>(14,833)</u>	\$	<u>(14,833)</u> 1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>(36)</u>		<u>(36)</u> 2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>(153,947)</u>		<u>(153,947)</u> 3
4	V	<u>19 Adjustment for Related Organization</u>	<u>244,896</u>	<u>Heritage Operations Group, LLC</u>				<u>(244,896)</u> 4
5	V							
6	V	<u>34 Adjustment for Related Organization</u>	<u>433,620</u>	<u>Heritage Manor Real Estate, LLC</u>				<u>(433,620)</u> 6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>34,235</u>		<u>34,235</u> 7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>154,728</u>		<u>154,728</u> 8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>153,350</u>		<u>153,350</u> 9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>58,574</u>		<u>58,574</u> 10
11	V							
12	V							
13	V							
14	<b>Total</b>		\$ <u>678,516</u>			\$ <u>232,071</u>	\$ *	<u>(446,445)</u> 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		\$	\$ 3,632	15
16	V	2 Food Purchase		Heritage Operations Group			48	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			1,319	19
20	V	6 Maintenance		Heritage Operations Group			19,936	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			581	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			1,044	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			15,400	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			8,691	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			319,107	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			41,622	34
35	V	23 Inservice Training & Education		Heritage Operations Group			1,563	35
36	V	24 Travel and Seminar		Heritage Operations Group			6,695	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			22,446	38
39	Total		\$			\$	0	\$ * 442,088 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			25,403	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			5,521	20
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			5,590	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	\$ * 36,514 39

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

Facility Name & ID Number Heritage Manor Staunton LLC # 48876 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 Staunton LLC # 48876 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	90	\$ 3,632	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	90	48	2
3	3	Housekeeping	Beds	2,578	26	0	0	90	0	3
4	4	Laundry	Beds	2,578	26	111	0	90	4	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	90	1,319	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	90	19,936	6
7	7	Other	Beds	2,578	26	0	0	90	0	7
8	9	Medical Director	Beds	2,578	26	0	0	90	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	16,650	12,036	90	581	9
10	11	Activities	Beds	2,578	26	0	0	90	0	10
11	12	Social Service	Beds	2,578	26	0	0	90	0	11
12	13	Nurse Aide Training	Beds	2,578	26	29,896	28,423	90	1,044	12
13	14	Program Transportation	Beds	2,578	26	0	0	90	0	13
14	15	Other	Beds	2,578	26	0	0	90	0	14
15	17	Administrative	Beds	2,578	26	0	0	90	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	90	0	16
17	19	Professional Services	Beds	2,578	26	441,112	0	90	15,400	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	90	8,691	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	90	319,107	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	90	41,622	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	90	1,563	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	90	6,695	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	90	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	90	22,446	24
25	TOTALS					\$ 12,663,368	\$ 8,998,151		\$ 442,088	25

Facility Name & ID Number Heritage Manor Staunton LLC

# 48876

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	\$	90	\$	1
2	30	Depreciation	Beds	2,578	26	727,658	90	25,403	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		90		3
4	32	Interest	Beds	2,578	26		90		4
5	33	Real Estate Taxes	Beds	2,578	26		90		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134	90	5,521	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109	90	5,590	7
8	36	Other	Beds	2,578	26		90		8
9	38	Medically Nec Transportation	Beds	2,578	26		90		9
10	39	Ancillary Service Centers	Beds	2,578	26		90		10
11	40	Barber and Beauty Shops	Beds	2,578	26		90		11
12	41	Coffee and Gift Shops	Beds	2,578	26		90		12
13	42	Other	Beds	2,578	26		90		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	\$	\$ 36,514	25

Facility Name & ID Number

Heritage Manor Staunton LLC

# 48876

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Busey Bank		x	Mortgage			\$	\$		\$ 154,728	1									
2	Busey Bank		x	Loan Fee Amortization						58,574	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	Busey Bank		x	Working Capital						52,356	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 265,658	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(3,563)	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (3,563)	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 262,095	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 Staunton LLC

# 48876

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.)		\$	34,235	2
3. Under or (over) accrual (line 2 minus line 1).		\$	34,235	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	34,235	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	31,965	8	
	2014	32,557	9	
	2015	32,767	10	
	2016	34,509	11	
	2017	34,235	12	
				<b>FOR BHF USE ONLY</b>
	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.**



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24,700 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>53,090</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>53,090</u>	3

Facility Name & ID Number Heritage Manor Staunton LLC

# 48876

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	90			\$ 2,016,995	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	1996 Improvements		1996	6,049					
10	1997 Improvements - None		1997						
11	1998 Improvements		1998	63,807					
12	1999 Improvements		1999	31,488					
13	2000 Improvements		2000	6,918					
14	2001 Improvements		2001	2,967					
15	2002 Improvements		2002	14,740					
16	2003 Improvements		2003	8,174					
17	2004 Improvements		2004	82,598					
18	2005 Improvements		2005	162,277					
19	2006 Improvements		2006	39,307					
20	2007 Improvements		2007	264,816					
21	2008 Improvements		2008	197,174					
22	2009 Improvements		2009	8,751					
23	2010 Improvements		2010	20,073					
24	2011 Improvements		2011	16,203					
25	2012 Improvements		2012	9,046					
26									
27	Generator Replacement		2013	55,133					
28	Water Heater		2013	8,737					
29	PTAC Installations		2013	8,907					
30	Replace (3) Valve Actuators & Thermostats		2013	6,454					
31									
32									
33									
34	C/O Allocation				25,403		25,403		
35	Book Depreciation				128,156		128,156		
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	7,581						38
39	Reface (22) Wardrobe Units	2014	29,110						39
40									40
41	Install (2) new hollow metal doors	2015	3,406						41
42	Install security doors with appropriate electronics	2015	22,769						42
43	Replace (6) PTAC units	2015	7,995						43
44	Replace compressor for PT RTU	2015	2,617						44
45	Replace AC rooftop unit for kitchen and dining room	2015	17,051						45
46									46
47	No 2016 Improvements	2016							47
48									48
49	No 2017 Improvements	2017							49
50									50
51	(2) full boiler replacements	2018	55,128						51
52	Replace laundry room air conditioner	2018	7,860						52
53	Install new PTAC units	2018	5,058						53
54	Replace culvert - North ditches	2018	4,566						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)		\$ 3,193,755	\$ 153,559		\$ 153,559	\$	\$	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	\$ 667,519	\$ 22,536	\$ 22,536	\$		\$	71
72	Current Year Purchases	12,891						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 680,410	\$ 22,536	\$ 22,536	\$		\$	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		2006 Chevy Uplander van	2012	\$ 18,608	\$ 2,658	\$ 2,658	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 18,608	\$ 2,658	\$ 2,658	\$		\$	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)	\$ 3,945,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,753	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,753	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	<b>TOTAL</b>				\$			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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 15,117 Description: Televisions and office equipment

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		4,059		4,059
3	Classroom Wages (a)		8,731		8,731
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 12,790	\$	\$ 12,790
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	12,790		

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	240,293	\$		\$	240,293					1
2	Licensed Speech and Language Development Therapist		hrs				25,708				25,708					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs				210,340		678		211,018					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						184,811		184,811					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):						22,533				22,533					13
14	TOTAL			\$		\$	498,874	\$	185,489	\$	684,363					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 Staunton LLC

# 48876

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,459	\$	1
2	Cash-Patient Deposits	11,541		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	514,130		3
4	Supply Inventory (priced at <u>FIFO</u> )	11,130		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,784		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	566,438		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,106,482	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,106,482	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 78,922	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,541		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,121		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,210		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Bed Tax</u>	11,357		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 374,151	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 374,151	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 732,331	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,106,482	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>746,507</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>746,507</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(14,176)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(14,176)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>732,331</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,685,470	1
2	Discounts and Allowances for all Levels	(1,662,482)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,022,988	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,653,701	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,653,701	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,290	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	339,229	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,485	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 357,004	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,563	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,563	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,037,256	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	791,588	31
32	Health Care	1,942,071	32
33	General Administration	1,328,830	33
<b>B. Capital Expense</b>			
34	Ownership	501,093	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	487,850	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,051,432	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(14,176)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (14,176)	43

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

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

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

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

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

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

# **48876**

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	1,706	1,815	\$ 68,775	\$ 37.89	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,691	6,054	205,950	34.02	3
4	Licensed Practical Nurses	9,949	10,584	273,814	25.87	4
5	CNAs & Orderlies	46,474	49,440	786,790	15.91	5
6	CNA Trainees	956	1,017	8,731	8.59	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,355	1,441	32,325	22.43	8
9	Activity Director					9
10	Activity Assistants	3,363	3,578	39,349	11.00	10
11	Social Service Workers	1,706	1,815	41,744	23.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,262	14,108	167,638	11.88	15
16	Dishwashers					16
17	Maintenance Workers	3,072	3,268	59,744	18.28	17
18	Housekeepers	9,256	9,847	108,475	11.02	18
19	Laundry	3,398	3,615	37,811	10.46	19
20	Administrator	1,955	2,080	89,476	43.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,835	6,207	148,916	23.99	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)	107,978	114,869	\$ 2,069,538 *	\$ 18.02	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		\$ 6,056		35
36	Medical Director		19,722		36
37	Medical Records Consultant		812		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,070		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		2,199		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,859		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		143,273		52
53	TOTAL (lines 50 - 52)		\$ 143,273		53



Facility Name & ID Number Heritage Manor Staunton LLC# 48876

Report Period Beginning:

1/1/2018Ending: 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. \$ 169,953  
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. \$ 5,117
- (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 - Staunton  
IDPH ID# 48876  
HFS Cost Report - December 31, 2018  
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 184,812
Purchased Hospital Services	4,994
Purchased Laboratory Services	16,937
Purchased Radiology Services	601
Amount Reclassified to Line 39	<u>\$ 207,344</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (49,275)
Provider Assesment Fee - \$6.07	<u>(120,678)</u>
	<u>(169,953)</u>
Provider Participation Fee - Line 42	<u>169,953</u>