

Facility Name & ID Number Heritage Manor Walnut LLC

53405 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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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	10,435	5,630	1,644	17,709	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,435	5,630	1,644	17,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.25%

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 2015

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/2014 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 1,644

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 Walnut LLC # 53405 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	168,364	10,245	7,230	185,839		185,839	2,502	188,341		1
2	Food Purchase		142,256		142,256		142,256	33	142,289		2
3	Housekeeping	46,217	15,093		61,310		61,310		61,310		3
4	Laundry	58,943	15,986		74,929		74,929	3	74,932		4
5	Heat and Other Utilities			55,243	55,243		55,243	909	56,152		5
6	Maintenance	59,519	57,383	46,962	163,864		163,864	13,734	177,598		6
7	Other (specify):*										7
8	TOTAL General Services	333,043	240,963	109,435	683,441		683,441	17,181	700,622		8
	B. Health Care and Programs										
9	Medical Director			8,388	8,388		8,388		8,388		9
10	Nursing and Medical Records	1,052,205	80,272	5,355	1,137,832		1,137,832	(12,908)	1,124,924		10
10a	Therapy		141,207	19,500	160,707	(159,323)	1,384		1,384		10a
11	Activities	40,235	11,003		51,238		51,238		51,238		11
12	Social Services	82,348		3,240	85,588		85,588		85,588		12
13	CNA Training							719	719		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,174,788	232,482	36,483	1,443,753	(159,323)	1,284,430	(12,189)	1,272,241		16
	C. General Administration										
17	Administrative	85,505			85,505		85,505		85,505		17
18	Directors Fees										18
19	Professional Services			194,031	194,031		194,031	(182,558)	11,473		19
20	Dues, Fees, Subscriptions & Promotions			160,917	160,917	(132,473)	28,444	(15,325)	13,119		20
21	Clerical & General Office Expenses	121,357	22,573	6,272	150,202		150,202	219,829	370,031		21
22	Employee Benefits & Payroll Taxes			386,177	386,177		386,177	28,673	414,850		22
23	Inservice Training & Education			2,515	2,515		2,515	933	3,448		23
24	Travel and Seminar			6,629	6,629		6,629	(1,630)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,472	30,472		30,472	15,463	45,935		26
27	Other (specify):*			33,222	33,222		33,222	(33,222)			27
28	TOTAL General Administration	206,862	22,573	820,235	1,049,670	(132,473)	917,197	32,163	949,360		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,714,693	496,018	966,153	3,176,864	(291,796)	2,885,068	37,155	2,922,223		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							70,252	70,252		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			36,645	36,645		36,645	41,536	78,181		32
33	Real Estate Taxes							25,765	25,765		33
34	Rent-Facility & Grounds			272,260	272,260		272,260	(269,532)	2,728		34
35	Rent-Equipment & Vehicles			7,945	7,945		7,945	3,851	11,796		35
36	Other (specify):*										36
37	TOTAL Ownership			316,850	316,850		316,850	(128,128)	188,722		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			366,782	366,782	159,323	526,105	104,399	630,504		39
40	Barber and Beauty Shops			7,319	7,319		7,319		7,319		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					132,473	132,473		132,473		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			374,101	374,101	291,796	665,897	104,399	770,296		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,714,693	496,018	1,657,104	3,867,815		3,867,815	13,426	3,881,241		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 Walnut LLC

53405

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	(1,075)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,280)			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				18
19	Entertainment	(6,242)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,605)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,222)			24
25	Fund Raising, Advertising and Promotional	(21,312)			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)	\$ (75,736)		\$	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)	89,162		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 89,162		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 13,426		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 Walnut LLC

ID# 53405

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		(1,075)	34	22
23		(8,605)	19	23
24		(33,222)	27	24
25		(21,312)	20	25
26		(6,242)	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	(70,456)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Walnut LLC# 53405

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	2,502	0	0	0	0	0	0	0	0	2,502	1
2	Food Purchase	0	0	33	0	0	0	0	0	0	0	0	33	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	3	0	0	0	0	0	0	0	0	3	4
5	Heat and Other Utilities	0	0	909	0	0	0	0	0	0	0	0	909	5
6	Maintenance	0	0	13,734	0	0	0	0	0	0	0	0	13,734	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	17,181	0	0	0	0	0	0	0	0	17,181	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	(13,308)	400	0	0	0	0	0	0	0	0	(12,908)	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	719	0	0	0	0	0	0	0	0	719	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	(13,308)	1,119	0	0	0	0	0	0	0	0	(12,189)	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	(8,605)	(184,562)	10,609	0	0	0	0	0	0	0	0	(182,558)	19
20	Fees, Subscriptions & Promotions	(21,312)	0	5,987	0	0	0	0	0	0	0	0	(15,325)	20
21	Clerical & General Office Expenses	0	0	219,829	0	0	0	0	0	0	0	0	219,829	21
22	Employee Benefits & Payroll Taxes	0	0	28,673	0	0	0	0	0	0	0	0	28,673	22
23	Inservice Training & Education	0	(144)	1,077	0	0	0	0	0	0	0	0	933	23
24	Travel and Seminar	(6,242)	0	4,612	0	0	0	0	0	0	0	0	(1,630)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	15,463	0	0	0	0	0	0	0	0	15,463	26
27	Other (specify):*	(33,222)	0	0	0	0	0	0	0	0	0	0	(33,222)	27
28	TOTAL General Administration	(69,381)	(184,706)	286,250	0	0	0	0	0	0	0	0	32,163	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,381)	(198,014)	304,550	0	0	0	0	0	0	0	0	37,155	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Walnut LLC

53405

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	52,752	0	17,500	0	0	0	0	0	0	0	70,252	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,280)	46,816	0	0	0	0	0	0	0	0	0	41,536	32
33	Real Estate Taxes	0	25,765	0	0	0	0	0	0	0	0	0	25,765	33
34	Rent-Facility & Grounds	(1,075)	(272,260)	0	3,803	0	0	0	0	0	0	0	(269,532)	34
35	Rent-Equipment & Vehicles	0	0	0	3,851	0	0	0	0	0	0	0	3,851	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,355)	(146,927)	0	25,154	0	(128,128)	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	104,399	0	0	0	0	0	0	0	0	0	104,399	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	104,399	0	0	0	0	0	0	0	0	0	104,399	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(75,736)	(240,542)	304,550	25,154	0	13,426	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>(13,308)</u>	\$ <u>(13,308)</u>	1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>(144)</u>	<u>(144)</u>	2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>104,399</u>	<u>104,399</u>	3
4	V	<u>19 Adjustment for Related Organization</u>	<u>184,562</u>	<u>Heritage Operations Group, LLC</u>			<u>(184,562)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>272,260</u>	<u>Heritage Manor Real Estate, LLC</u>			<u>(272,260)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>25,765</u>	<u>25,765</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>45,241</u>	<u>45,241</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>52,752</u>	<u>52,752</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>1,575</u>	<u>1,575</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>456,822</u>			\$ <u>216,280</u>	\$ * <u>(240,542)</u>	14

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

Facility Name & ID Number

Heritage Manor Walnut LLC

53405

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		\$	\$ 2,502	15
16	V	2 Food Purchase		Heritage Operations Group			33	16
17	V	3 Housekeeping		Heritage Operations Group			0	17
18	V	4 Laundry		Heritage Operations Group			3	18
19	V	5 Heat & Other Utilities		Heritage Operations Group			909	19
20	V	6 Maintenance		Heritage Operations Group			13,734	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			400	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			719	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			10,609	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			5,987	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			219,829	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			28,673	34
35	V	23 Inservice Training & Education		Heritage Operations Group			1,077	35
36	V	24 Travel and Seminar		Heritage Operations Group			4,612	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			15,463	38
39	Total		\$			\$	0	\$ * 304,550 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			17,500	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			3,803	20
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			3,851	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	\$ * 25,154

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

Facility Name & ID Number Heritage Manor Walnut LLC # 53405 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 Walnut LLC

53405

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	62	\$ 2,502	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	62	33	2
3	3	Housekeeping	Beds	2,578	26	0	0	62	0	3
4	4	Laundry	Beds	2,578	26	111	0	62	3	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	62	909	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	62	13,734	6
7	7	Other	Beds	2,578	26	0	0	62	0	7
8	9	Medical Director	Beds	2,578	26	0	0	62	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	16,650	12,036	62	400	9
10	11	Activities	Beds	2,578	26	0	0	62	0	10
11	12	Social Service	Beds	2,578	26	0	0	62	0	11
12	13	Nurse Aide Training	Beds	2,578	26	29,896	28,423	62	719	12
13	14	Program Transportation	Beds	2,578	26	0	0	62	0	13
14	15	Other	Beds	2,578	26	0	0	62	0	14
15	17	Administrative	Beds	2,578	26	0	0	62	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	62	0	16
17	19	Professional Services	Beds	2,578	26	441,112	0	62	10,609	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	62	5,987	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	62	219,829	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	62	28,673	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	62	1,077	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	62	4,612	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	62	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	62	15,463	24
25	TOTALS					\$ 12,663,368	\$ 8,998,151		\$ 304,550	25

Facility Name & ID Number Heritage Manor Walnut LLC

53405

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	27	Other	Beds	2,578	26	\$	62	\$	1
2	30	Depreciation	Beds	2,578	26	727,658	62	17,500	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		62		3
4	32	Interest	Beds	2,578	26		62		4
5	33	Real Estate Taxes	Beds	2,578	26		62		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134	62	3,803	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109	62	3,851	7
8	36	Other	Beds	2,578	26		62		8
9	38	Medically Nec Transportation	Beds	2,578	26		62		9
10	39	Ancillary Service Centers	Beds	2,578	26		62		10
11	40	Barber and Beauty Shops	Beds	2,578	26		62		11
12	41	Coffee and Gift Shops	Beds	2,578	26		62		12
13	42	Other	Beds	2,578	26		62		13
14							62		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	\$		\$ 25,154	25

Facility Name & ID Number

Heritage Manor Walnut LLC

53405

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	Morton Community Bank		x	Mortgage			\$	\$		\$ 45,241	1									
2	Morton Community Bank		x	Loan Fee Amortization						1,575	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Busey Bank		x	Working Capital						36,068	6									
7	Morton Community Bank		x	Working Capital						577	7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 83,461	9									
B. Non-Facility Related*																				
10	Interest Income									(5,280)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (5,280)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 78,181	15									

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 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.)	\$	25,765	2
3. Under or (over) accrual (line 2 minus line 1).	\$	25,765	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.	\$	25,765	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	33,172	8
	2014	34,356	9
	2015	34,043	10
	2016	27,116	11
	2017	25,765	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,000 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).

Walnut Apartments - Independent living units located adjacent to SNF facility. Only combined cost is real estate tax expense

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>20,610</u>	1
2					2
3	TOTALS			\$ <u>20,610</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	62			\$ 469,470	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Improvements		1977	24,660					9
10	Improvements		1979	55,005					10
11	Improvements		1978	3,810					11
12	Improvements		1980	13,010					12
13	Improvements		1981	6,721					13
14	Improvements		1982	4,293					14
15	Improvements		1983	2,724					15
16	Improvements		1984	10,591					16
17	Improvements		1985	15,586					17
18	Improvements		1988	13,679					18
19	Improvements		1991	28,639					19
20	Improvements		1992	28,595					20
21	Improvements		1993	8,420					21
22	Improvements		1994	24,280					22
23	Improvements		1995	23,165					23
24	Improvements		1996	17,911					24
25	Improvements		1999	44,319					25
26	Improvements		2000	3,857					26
27	Improvements		2001	7,754					27
28	Improvements		2002	11,032					28
29	Improvements		2003	15,415					29
30	Improvements		2004	4,614					30
31	Improvements		2005	14,341					31
32									32
33									33
34	C/O Allocation				17,500		17,500		34
35	Book Depreciation				50,723		50,723		35
36									36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38	Improvements	2006	11,150					38	
39	Improvements	2007	22,776					39	
40	Improvements	2008	26,317					40	
41	Improvements	2009	91,067					41	
42	Improvements	2010	34,257					42	
43	Improvements	2011	128,571					43	
44	Improvements	2012	23,837					44	
45								45	
46	HVAC Unit Purchase and Installation	2013	4,241					46	
47	Replace and Install 4 Ton A/C Units (2)	2014	6,320					47	
48	Replace and Install New Water Heater	2014	7,200					48	
49								49	
50	Construct new sign depicting new facility name	2015	10,557					50	
51	Dining room remodeling - removal of old flooring, asbestos	2015	19,758					51	
52	removal, new flooring, painting, new plumbing and new							52	
53	light fixtures.							53	
54								54	
55	Replace laundry room cooling unit	2016	5,671					55	
56								56	
57	Install new inside mount blinds in resident rooms	2017	5,053					57	
58	Replace water heater	2017	11,220					58	
59								59	
60	Replace flooring - Day Room	2018	4,400					60	
61	Replace vent piping - Laundry Room	2018	3,985					61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 1,268,271	\$ 68,223		\$ 68,223	\$	\$	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	\$ 498,459	\$ 2,029	\$ 2,029	\$		\$	71
72	Current Year Purchases	18,782						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 517,241	\$ 2,029	\$ 2,029	\$		\$	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		2008 Van	2007	\$ 58,504	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 58,504	\$	\$	\$		\$	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)	\$ 1,864,626	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,252	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,252	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. _____ /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: \$ 7,945 Description: Televisions and office equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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)	\$			

- (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.

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	

- (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	\$		\$ 164,662	\$		\$ 164,662	1
2	Licensed Speech and Language Development Therapist		hrs			18,761			18,761	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			183,359	1,384		184,743	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				139,823		139,823	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					19,500			19,500	13
14	TOTAL			\$		\$ 386,282	\$ 141,207		\$ 527,489	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 Walnut LLC

53405

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	\$ 22,616	\$	1
2	Cash-Patient Deposits	6,147		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	467,726		3
4	Supply Inventory (priced at <u>FIFO</u>)	6,806		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,413		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(90,464)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 415,244	\$	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)	\$ 415,244	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 66,311	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,147		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,820		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,614		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>	7,660		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 256,552	\$	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)	\$ 256,552	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 158,692	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 415,244	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 197,162	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 197,162	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(38,470)	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)	\$ (38,470)	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)	\$ 158,692	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor Walnut LLC

53405

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	\$ 3,474,376	1
2	Discounts and Allowances for all Levels	(1,084,631)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,389,745	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,171,726	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,171,726	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	7,418	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,075	16
17	Sale of Drugs	254,054	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	47	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 262,594	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,280	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,280	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,829,345	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	683,441	31
32	Health Care	1,443,753	32
33	General Administration	1,049,670	33
B. Capital Expense			
34	Ownership	316,850	34
C. Ancillary Expense			
35	Special Cost Centers	374,101	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)*	\$ 3,867,815	40
41	Income before Income Taxes (line 30 minus line 40)**	(38,470)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (38,470)	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 Walnut LLC**

53405

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	1,350	1,436	\$ 57,178	\$ 39.82	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,549	5,903	187,034	31.68	3
4	Licensed Practical Nurses	9,498	10,105	260,652	25.79	4
5	CNAs & Orderlies	31,980	34,022	478,310	14.06	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,253	3,461	69,031	19.95	8
9	Activity Director					9
10	Activity Assistants	2,748	2,923	40,235	13.76	10
11	Social Service Workers	1,778	1,892	82,348	43.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,616	15,549	168,364	10.83	15
16	Dishwashers					16
17	Maintenance Workers	2,907	3,093	59,519	19.24	17
18	Housekeepers	4,082	4,343	46,217	10.64	18
19	Laundry	5,530	5,883	58,943	10.02	19
20	Administrator	1,955	2,080	85,505	41.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,007	4,263	121,357	28.47	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)	89,253	94,953	\$ 1,714,693 *	\$ 18.06	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		\$ 7,230		35
36	Medical Director		8,388		36
37	Medical Records Consultant		1,995		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,184		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,240		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,037		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 Walnut LLC

53405

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	
Dennis Grobe			\$ 85,505	Workers' Compensation Insurance	\$ 28,957	IDPH License Fee	\$	
				Unemployment Compensation Insurance	6,746	Advertising: Employee Recruitment	3,950	
				FICA Taxes	131,174	Health Care Worker Background Check (Indicate # of checks performed)	650	
				Employee Health Insurance	202,636	Patient Background Checks		
				Employee Meals		PR	7,381	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,874	
				Other Benefits	16,664	License & Fees	1,135	
				Central Office Allocation	28,673	Central Office Allocation	5,987	
						Less: Public Relations Expense	(7,381)	
						Non-allowable advertising	(2,477)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,505	TOTAL (agree to Schedule V, line 22, col.8)	\$ 414,850	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,119	
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	
								4,983
								0
							Seminar Expense	1,646
								(1,630)
							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		\$ 185,426					
Legal adj to Zero			8,605					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 194,031					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor Walnut LLC# 53405

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. \$ 132,473
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. \$ 1,765
- (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 - Walnut
IDPH ID# 53405
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	\$ 139,823
Purchased Hospital Services	19,500
Purchased Laboratory Services	0
Purchased Radiology Services	0
Amount Reclassified to Line 39	<u>\$ 159,323</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (33,945)
Provider Assesment Fee - \$6.07	<u>(98,528)</u>
	<u>(132,473)</u>
Provider Participation Fee - Line 42	<u>132,473</u>