

Facility Name & ID Number Heritage Manor Dwight LLC

0050492 Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,676	8,155	3,401	26,232	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,676	8,155	3,401	26,232	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.12%

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 3/6/1992

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 92 and days of care provided 3,401

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 Dwight LLC # 0050492 Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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	262,752	21,161	8,582	292,495		292,495	4,235	296,730		1
2	Food Purchase		216,694		216,694		216,694	(20)	216,674		2
3	Housekeeping	72,414	28,662		101,076		101,076		101,076		3
4	Laundry	59,903	14,855		74,758		74,758		74,758		4
5	Heat and Other Utilities			126,003	126,003		126,003	1,526	127,529		5
6	Maintenance	92,926	72,201	98,114	263,241		263,241	17,011	280,252		6
7	Other (specify):*										7
8	TOTAL General Services	487,995	353,573	232,699	1,074,267		1,074,267	22,752	1,097,019		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,864,071	150,964	86,694	2,101,729		2,101,729	(33,081)	2,068,648		10
10a	Therapy		351,130	12,523	363,653	(363,653)					10a
11	Activities	84,868	7,180		92,048		92,048	169	92,217		11
12	Social Services	40,441		3,521	43,962		43,962		43,962		12
13	CNA Training	801	(4,248)		(3,447)		(3,447)	22	(3,425)		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,990,181	505,026	113,538	2,608,745	(363,653)	2,245,092	(32,890)	2,212,202		16
	C. General Administration										
17	Administrative	69,002			69,002		69,002		69,002		17
18	Directors Fees										18
19	Professional Services			672,617	672,617		672,617	(651,975)	20,642		19
20	Dues, Fees, Subscriptions & Promotions			222,913	222,913	(190,350)	32,563	(20,855)	11,708		20
21	Clerical & General Office Expenses	268,606	28,170	6,604	303,380		303,380	368,880	672,260		21
22	Employee Benefits & Payroll Taxes			443,621	443,621		443,621	37,724	481,345		22
23	Inservice Training & Education			187	187		187	1,284	1,471		23
24	Travel and Seminar			8,324	8,324		8,324	(3,325)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,325	40,325		40,325	67,695	108,020		26
27	Other (specify):* Lost resident items			97,437	97,437		97,437	(97,161)	276		27
28	TOTAL General Administration	337,608	28,170	1,492,028	1,857,806	(190,350)	1,667,456	(297,733)	1,369,723		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,815,784	886,769	1,838,265	5,540,818	(554,003)	4,986,815	(307,871)	4,678,944		29

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

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

Facility Name & ID Number Heritage Manor Dwight LLC

#0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			158,810	158,810		158,810	22,692	181,502			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,322	54,322		54,322	(2,383)	51,939			32
33	Real Estate Taxes			64,405	64,405		64,405		64,405			33
34	Rent-Facility & Grounds			217,875	217,875		217,875	6,059	223,934			34
35	Rent-Equipment & Vehicles			64,194	64,194		64,194	8,553	72,747			35
36	Other (specify):*											36
37	TOTAL Ownership			559,606	559,606		559,606	34,921	594,527			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			451,013	451,013	363,653	814,666	157,441	972,107			39
40	Barber and Beauty Shops			4,147	4,147		4,147		4,147			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					190,350	190,350		190,350			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			455,160	455,160	554,003	1,009,163	157,441	1,166,604			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,815,784	886,769	2,853,031	6,555,584		6,555,584	(115,509)	6,440,075			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,847)			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	(421)			17
18	Fines and Penalties				18
19	Entertainment	(10,423)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(374,653)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(97,161)			24
25	Fund Raising, Advertising and Promotional	(21,356)			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)	\$ (507,861)		\$	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)	392,352		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 392,352		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (115,509)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Heritage Manor Dwight LLC

ID# 0050492

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

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		(421)	20	22
23		(374,653)	19	23
24		(97,161)	27	24
25		(21,356)	20	25
26		(10,423)	24	26
27		0	6	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	(504,014)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Dwight LLC# 0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,235	0	0	0	0	0	0	0	0	4,235	1
2	Food Purchase	0	0	(20)	0	0	0	0	0	0	0	0	(20)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,526	0	0	0	0	0	0	0	0	1,526	5
6	Maintenance	0	0	17,011	0	0	0	0	0	0	0	0	17,011	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,752	0	0	0	0	0	0	0	0	22,752	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	(33,797)	716	0	0	0	0	0	0	0	0	(33,081)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	169	0	0	0	0	0	0	0	0	169	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	22	0	0	0	0	0	0	0	0	22	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	(33,797)	907	0	0	0	0	0	0	0	0	(32,890)	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	(374,653)	(295,421)	18,099	0	0	0	0	0	0	0	0	(651,975)	19
20	Fees, Subscriptions & Promotions	(21,777)	0	922	0	0	0	0	0	0	0	0	(20,855)	20
21	Clerical & General Office Expenses	0	0	368,880	0	0	0	0	0	0	0	0	368,880	21
22	Employee Benefits & Payroll Taxes	0	0	37,724	0	0	0	0	0	0	0	0	37,724	22
23	Inservice Training & Education	0	0	1,284	0	0	0	0	0	0	0	0	1,284	23
24	Travel and Seminar	(10,423)	0	7,098	0	0	0	0	0	0	0	0	(3,325)	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	67,695	0	0	0	0	0	0	0	0	67,695	26
27	Other (specify):*	(97,161)	0	0	0	0	0	0	0	0	0	0	(97,161)	27
28	TOTAL General Administration	(504,014)	(295,421)	501,702	0	0	0	0	0	0	0	0	(297,733)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(504,014)	(329,218)	525,361	0	0	0	0	0	0	0	0	(307,871)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Dwight LLC# 0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	0	0	22,692	0	0	0	0	0	0	0	22,692	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,847)	0	0	1,464	0	0	0	0	0	0	0	(2,383)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,059	0	0	0	0	0	0	0	6,059	34
35	Rent-Equipment & Vehicles	0	0	0	8,553	0	0	0	0	0	0	0	8,553	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,847)	0	0	38,768	0	0	0	0	0	0	0	34,921	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	157,441	0	0	0	0	0	0	0	0	0	157,441	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	157,441	0	0	0	0	0	0	0	0	0	157,441	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(507,861)	(171,777)	525,361	38,768	0	0	0	0	0	0	0	(115,509)	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 Organiza</u>	\$	<u>GreenTree Pharmacy</u>		\$ <u>(33,797)</u>	\$ <u>(33,797)</u>	1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>				2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>157,441</u>	<u>157,441</u>	3
4	V	<u>19 Adjustment for Related Organization</u>	<u>295,421</u>	<u>Heritage Operations Group, LLC</u>			<u>(295,421)</u>	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>295,421</u>			\$ <u>123,644</u>	\$ * <u>(171,777)</u>	14

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

Facility Name & ID Number Heritage Manor Dwight LLC# 0050492Report Period Beginning: 1/1/2019Ending: 12/31/2019

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Operations Group		\$	4,235	15
16	V	2 Food Purchase		Heritage Operations Group			(20)	16
17	V	3 Housekeeping		Heritage Operations Group			0	17
18	V	4 Laundry		Heritage Operations Group			0	18
19	V	5 Heat & Other Utilities		Heritage Operations Group			1,526	19
20	V	6 Maintenance		Heritage Operations Group			17,011	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			716	23
24	V	11 Activities		Heritage Operations Group			169	24
25	V	12 Social Service		Heritage Operations Group			0	25
26	V	13 Nurse Aide Training		Heritage Operations Group			22	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			18,099	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			922	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			368,880	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			37,724	34
35	V	23 Inservice Training & Education		Heritage Operations Group			1,284	35
36	V	24 Travel and Seminar		Heritage Operations Group			7,098	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			67,695	38
39	Total		\$			\$	0	\$ * 525,361 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			22,692	16	
17	V	31 Amortization of Pre-Op & Org		Heritage Operations Group			0	17	
18	V	32 Interest		Heritage Operations Group			1,464	18	
19	V	33 Real Estate Taxes		Heritage Operations Group			0	19	
20	V	34 Rent-Facility & Grounds		Heritage Operations Group			6,059	20	
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			8,553	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	\$ * 38,768	39

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

Facility Name & ID Number Heritage Manor Dwight LLC # 0050492 Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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	0	0			\$ 0	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 Dwight LLC

0050492

Report Period Beginning:

1/1/2019

Ending: 2/31/2019

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 LLC

Street Address

115 W Jefferson Street

City / State / Zip Code

Bloomington IL 61701

Phone Number

(309 828-4361

Fax Number

(309 829-5477

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	2,493	25	\$ 114,750	\$ 114,730	92	\$ 4,235	1
2	2	Food Purchase	Beds	2,493	25	(550)	0	92	(20)	2
3	3	Housekeeping	Beds	2,493	25	0	0	92	0	3
4	4	Laundry	Beds	2,493	25	0	0	92	0	4
5	5	Heat & Other Utilities	Beds	2,493	25	41,338	0	92	1,526	5
6	6	Maintenance	Beds	2,493	25	460,950	77,639	92	17,011	6
7	7	Other	Beds	2,493	25	0	0	92	0	7
8	9	Medical Director	Beds	2,493	25	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	19,407	18,673	92	716	9
10	11	Activities	Beds	2,493	25	4,591	0	92	169	10
11	12	Social Service	Beds	2,493	25	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,493	25	586	457	92	22	12
13	14	Program Transportation	Beds	2,493	25	0	0	92	0	13
14	15	Other	Beds	2,493	25	0	0	92	0	14
15	17	Administrative	Beds	2,493	25	0	0	92	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	92	0	16
17	19	Professional Services	Beds	2,493	25	490,432	0	92	18,099	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	24,973	0	92	922	18
19	21	Clerical & General Office Expense	Beds	2,493	25	9,995,851	9,636,092	92	368,880	19
20	22	Employee Benefits & Payroll Tax	Beds	2,493	25	1,022,249	0	92	37,724	20
21	23	Inservice Training & Education	Beds	2,493	25	34,795	0	92	1,284	21
22	24	Travel and Seminar	Beds	2,493	25	192,345	0	92	7,098	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,834,390	0	92	67,695	24
25	TOTALS					\$ 14,236,107	\$ 9,847,591		\$ 525,361	25

Facility Name & ID Number Heritage Manor Dwight LLC

0050492 Report Period Beginning: 1/1/2019

Ending: 2/31/2019

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 LLC
 Street Address 115 W Jefferson Street
 City / State / Zip Code Bloomington IL 61701
 Phone Number (309 828-4361
 Fax Number (309 829-5477

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	2,493	25	\$	92	\$	1
2	30	Depreciation	Beds	2,493	25	614,893	92	22,692	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		92		3
4	32	Interest	Beds	2,493	25	39,664	92	1,464	4
5	33	Real Estate Taxes	Beds	2,493	25		92		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	164,191	92	6,059	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	231,765	92	8,553	7
8	36	Other	Beds	2,493	25		92		8
9	38	Medically Nec Transportation	Beds	2,493	25		92		9
10	39	Ancillary Service Centers	Beds	2,493	25		92		10
11	40	Barber and Beauty Shops	Beds	2,493	25		92		11
12	41	Coffee and Gift Shops	Beds	2,493	25		92		12
13	42	Other	Beds	2,493	25		92		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					\$ 1,050,513	\$	\$ 38,768	25

Facility Name & ID Number

Heritage Manor Dwight LLC

0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Busey Bank	XX	Working Capital						54,322	6										
7										7										
8										8										
9	TOTAL Facility Related								54,322	9										
B. Non-Facility Related*																				
10	Interest Income								(3,847)	10										
11										11										
12	Allocated Corporate								1,464	12										
13										13										
14	TOTAL Non-Facility Related								(2,383)	14										
15	TOTALS (line 9+line14)								51,939	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.)

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Dwight LLC COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050492

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2018 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2018.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>050504483019</u>	_____	\$ <u>56,062.00</u>	\$ <u>56,062.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>56,062.00</u></u>	\$ <u><u>56,062.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES XX NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation*. Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Heritage Manor Dwight LLC

0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (xx) (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. (xx) (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 (xx)

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.

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	92		1972	1972	\$ 1,006,686	\$		\$	\$	\$
5					323,779					
6										
7										
8										
	Improvement Type**									
9		1992 Improvements		1992	8,456					
10		1993 Improvements		1993	586,243					
11		1994 Improvements		1994	12,874					
12		1995 Improvements		1995	496					
13		1996 Improvements		1996	7,350					
14		1997 Improvements		1997	119,787					
15		1998 Improvements		1998	19,959					
16		1999 Improvements		1999	9,926					
17		2000 Improvements		2000	2,830					
18		2001 Improvements		2001	14,572					
19		2002 Improvements		2002	47,984					
20		2003 Improvements		2003	11,616					
21		2004 Improvements		2004	21,939					
22		2005 Improvements		2005	29,372					
23		2006 Improvements		2006	113,123					
24		2007 Improvements		2007	77,078					
25		2008 Improvements		2008	28,139					
26		2009 Improvements		2009	310,836					
27		2010 Improvements		2010	936,394					
28		2011 Improvements		2011	133,396					
29		2012 Improvements		2012	22,690					
30		2013 Improvements		2013	15,027					
31										
32										
33										
34		C/O Allocation				22,692		22,692		
35		Book Depreciation				145,808		145,808		
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor Dwight LLC# 0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019**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	Rooftop AC Unit	2014	8,608						38
39	Install New Generator	2014	79,653						39
40	Roof Replacement-Partial	2014	23,796						40
41	Replace Water Heater	2014	13,400						41
42									42
43	Rooftop unit replacement - add Lennox; remove Trane	2015	12,936						43
44	Install amp disconnect to generator	2015	2,870						44
45	Replacment of condensor in mult zone compressor unit	2015	6,310						45
46									46
47	Upgrade of HVAC controls	2015	24,430						47
48									48
49	Replaced Carrier Unit compressor	2016	6,523						49
50									50
51	Replaced original boiler	2017	180,571						51
52	Replaced condensor coil	2017	14,036						52
53	Added emergency power to critical panel	2017	4,626						53
54									54
55	Infrastructure rewiring - IT related	2018	3,406						55
56	Replace gas water heater	2018	17,173						56
57	Replace air conditioner - laundry room	2018	6,525						57
58	Install outlets - emergency hallway	2018	7,503						58
59	Sewer re-piping	2018	16,880						59
60									60
61	Replace roof compressor	2019	9,135						61
62	Replace water line and mixing valve - Mechanical Room	2019	3,821						62
63	Shower room floor remediation -removal and disposition of ceramic tiles; installed new flooring	2019	18,173						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,320,927	\$ 168,500		\$ 168,500	\$	\$	70

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

Facility Name & ID Number Heritage Manor Dwight LLC

0050492

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	\$ 962,551	\$ 13,002	\$ 13,002	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 962,551	\$ 13,002	\$ 13,002	\$		\$	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		2009 Turtletop bus	2008	\$ 61,091	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,091	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,344,569	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 181,502	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,502	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heritage Manor Dwight LLC

0050492

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Dwight Continental Manor.

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:		92		\$ 217,875			3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 217,875			7

10. Effective dates of current rental agreement:

Beginning 4/1/2009

Ending 3/31/2029

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

Fiscal Year Ending Annual Rent

12.	<u>12/2020</u>	\$ <u>220,500</u>
13.	<u>12/2021</u>	\$ <u>220,500</u>
14.	<u>12/2022</u>	\$ <u>220,500</u>

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 64,194 Description: Office equipment & Televisions

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		(4,248)		(4,248)
3	Classroom Wages (a)				
4	Clinical Wages (b)		801		801
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	(3,447)	\$	(3,447)
10	SUM OF line 9, col. 1 and 2 (e)	\$	(3,447)		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 186,722	\$		\$ 186,722	1
2	Licensed Speech and Language Development Therapist		hrs			48,147			48,147	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			216,144	0		216,144	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				351,130		351,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					12,523			12,523	13
14	TOTAL			\$		\$ 463,536	\$ 351,130		\$ 814,666	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 Dwight LLC# 0050492Report Period Beginning: 1/1/2019Ending: 12/31/2019

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2019

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 907	\$	1
2	Cash-Patient Deposits	14,042		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	737,125		3
4	Supply Inventory (priced at <u>FIFO</u>)	24,899		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,862,013)		8
9	Other(specify):			9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ (2,085,040)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,052,140		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,010,370		16
17	Accumulated Depreciation (book methods)	(3,053,580)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 1,008,930	\$	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ (1,076,110)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 126,661	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,042		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	263,075		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	2,832		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,865		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>	12,073		36
37				37
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$ 477,548	\$	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
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$ 477,548	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,553,658)	\$	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$ (1,076,110)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,147,485)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,147,485)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(406,173)	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)	\$ (406,173)	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)	\$ (1,553,658)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor Dwight LLC

0050492

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

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	\$ 5,910,613	1
2	Discounts and Allowances for all Levels	(2,000,915)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,909,698	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,570,103	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,570,103	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	5,959	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	636,519	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	21,019	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 663,497	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,847	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,847	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund income	2,266	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,266	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,149,411	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,074,267	31
32	Health Care	2,608,745	32
33	General Administration	1,857,806	33
B. Capital Expense			
34	Ownership	559,606	34
C. Ancillary Expense			
35	Special Cost Centers	455,160	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)*	\$ 6,555,584	40
41	Income before Income Taxes (line 30 minus line 40)**	(406,173)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (406,173)	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 Dwight LLC

0050492

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

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	1,748	1,860	\$ 68,449	\$ 36.80	1
2	Assistant Director of Nursing	1,770	1,884	58,583	31.10	2
3	Registered Nurses	15,977	16,997	569,554	33.51	3
4	Licensed Practical Nurses	4,312	4,588	116,429	25.38	4
5	CNAs & Orderlies	52,648	56,009	928,908	16.58	5
6	CNA Trainees	88	94	801	8.52	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,607	4,901	122,148	24.92	8
9	Activity Director					9
10	Activity Assistants	5,953	6,333	84,868	13.40	10
11	Social Service Workers	1,720	1,830	40,441	22.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,486	21,794	262,752	12.06	15
16	Dishwashers					16
17	Maintenance Workers	4,555	4,846	92,926	19.18	17
18	Housekeepers	6,901	7,342	72,414	9.86	18
19	Laundry	5,221	5,555	59,903	10.78	19
20	Administrator	1,955	2,080	69,002	33.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,182	9,768	268,606	27.50	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)	137,123	145,881	\$ 2,815,784 *	\$ 19.30	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	\$ 8,582		35
36	Medical Director	10,800		36
37	Medical Records Consultant	1,414		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,111		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	3,521		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 29,428		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	78,760		52
53	TOTAL (lines 50 - 52)	\$ 78,760		53

Facility Name & ID Number Heritage Manor Dwight LLC

0050492

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

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 xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx 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. \$ 190,350
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 286
- (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? NA
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: MCK CPA's & Advisors
- (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 - Dwight
IDPH ID# 0050492
HFS Cost Report - December 31, 2019
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 351,130
Purchased Hospital Services	685
Purchased Laboratory Services	7,819
Purchased Radiology Services	4,019
Amount Reclassified to Line 39	\$ <u>363,653</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (50,370)
Provider Assesment Fee - \$6.07	<u>(139,980)</u>
	<u>(190,350)</u>
Provider Participation Fee	<u>190,350</u>