

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0052357 Facility Name: Heddington Oaks Address: 2223 W Heading Ave Peoria 61604 County: Peoria Telephone Number: (309) 636-3600 Fax #: (309) 636-3610 HFS ID Number: Date of Initial License for Current Owners: 11/30/1968 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other X GOVERNMENTAL State X County Other In the event there are further questions about this report, please contact: Name: Amanda Springborn Telephone Number: (314) 925-3838 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	664,468	29,379		693,847		693,847		693,847			1
2	Food Purchase		398,838		398,838		398,838	(5,070)	393,768			2
3	Housekeeping	294,544	41,494		336,038		336,038		336,038			3
4	Laundry	104,498	19,254		123,752		123,752		123,752			4
5	Heat and Other Utilities			357,765	357,765		357,765		357,765			5
6	Maintenance	86,825	17,554	183,112	287,491		287,491		287,491			6
7	Other (specify):*											7
8	TOTAL General Services	1,150,335	506,519	540,877	2,197,731		2,197,731	(5,070)	2,192,661			8
	B. Health Care and Programs											
9	Medical Director			5,004	5,004		5,004		5,004			9
10	Nursing and Medical Records	4,482,999	451,687	693,042	5,627,728		5,627,728	(43,895)	5,583,833			10
10a	Therapy											10a
11	Activities	287,285	4,961	570	292,816		292,816		292,816			11
12	Social Services	152,121		1,374	153,495		153,495		153,495			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,922,405	456,648	699,990	6,079,043		6,079,043	(43,895)	6,035,148			16
	C. General Administration											
17	Administrative			200,966	200,966		200,966	(59,977)	140,989			17
18	Directors Fees											18
19	Professional Services			617,333	617,333		617,333	202,340	819,673			19
20	Dues, Fees, Subscriptions & Promotions			28,180	28,180		28,180	(2,897)	25,283			20
21	Clerical & General Office Expenses	396,583	12,959	30,866	440,408		440,408	66,891	507,299			21
22	Employee Benefits & Payroll Taxes			858,319	858,319		858,319	667,354	1,525,673			22
23	Inservice Training & Education			1,923	1,923		1,923		1,923			23
24	Travel and Seminar			602	602		602		602			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			235,920	235,920		235,920	(211,381)	24,539			26
27	Other (specify):*											27
28	TOTAL General Administration	396,583	12,959	1,974,109	2,383,651		2,383,651	662,330	3,045,981			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,469,323	976,126	3,214,976	10,660,425		10,660,425	613,365	11,273,790			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			1,367,082	1,367,082		1,367,082	10,015	1,377,097			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,955,746	1,955,746		1,955,746	(35,492)	1,920,254			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			41,994	41,994		41,994		41,994			35
36	Other (specify):*											36
37	TOTAL Ownership			3,364,822	3,364,822		3,364,822	(25,477)	3,339,345			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,667	700,656	1,022,323		1,022,323		1,022,323			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			464,980	464,980		464,980		464,980			42
43	Other (specify):* Non-Allowable Cos			2,024,405	2,024,405		2,024,405	(2,024,405)				43
44	TOTAL Special Cost Centers		321,667	3,190,041	3,511,708		3,511,708	(2,024,405)	1,487,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,469,323	1,297,793	9,769,839	17,536,955		17,536,955	(1,436,517)	16,100,438			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,070)	2		4
5	Telephone, TV & Radio in Resident Rooms	(43,895)	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,960)	30		9
10	Interest and Other Investment Income	(35,492)	32		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	(49,544)	43		18
19	Entertainment	(558)	43		19
20	Contributions	625	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,856,492)	43		24
25	Fund Raising, Advertising and Promotional	(95,691)	43		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 See Page 5A	(25,642)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,117,719)		\$	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 Amount	2 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)	681,202		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 681,202		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,436,517)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Disallow Medicare Ancillary Costs	\$ (20,733)	43	1
2	Lobbying Cost	(2,897)	20	2
3	Disallow Demolition Costs of Bel-Wood	(2,012)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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19				19
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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	(25,642)		49

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
Peoria County	100	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	\$ 81,960	Peoria County	1	\$	(81,960)	1
2	V	18	County Board & Administration		Peoria County	1	21,983	21,983	2
3	V	19	County Auditor		Peoria County	1	9,928	9,928	3
4	V	19	Finance		Peoria County	1	221,453	221,453	4
5	V	19	Information Technology	556,440	Peoria County	1	471,866	(84,574)	5
6	V	19	State's Attorney		Peoria County	1	55,533	55,533	6
7	V	21	Human Resources		Peoria County	1	66,891	66,891	7
8	V	22	Retirement & Employer Taxes		Peoria County	1	1,283,118	1,283,118	8
9	V	22	Unemployment	10,593	Peoria County	1	2,648	(7,946)	9
10	V	22	Work Comp	200,788	Peoria County	1	50,183	(150,605)	10
11	V	22	Health Insurance	858,319	Peoria County	1	189,725	(668,594)	11
12	V	30	Depreciation - Equip & Vehicle		Peoria County	1	15,975	15,975	12
13	V				Peoria County	1			13
14	Total			\$ 1,708,100			\$ 2,389,302	\$ * 681,202	14

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Robert Baietto	Chairperson	Administrative	0.00	N/A	1	<1%	N/A	\$ N/A	N/A	1
2	Thomas O'Neill	Vice-Chairperson	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	2
3	Brian Elsasser	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	3
4	Rachel Parker	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	4
5	Lynn Pearson	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	5
6	Michael Phelan	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	6
7	Phillip Salzer	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	7
8	Carol Trumpe	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	8
9	Sharon Williams	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	9
10	James Dillon, a member of the Peoria County Board, works for Dillon Plumbing and abstains from all votes related to plumbing at facility nor does he work at facility.										10
11	Andrew Rand, a member of the Peoria County Board, is CEO of Advanced Medical Transport (AMT). Heddington Oaks uses AMT in the transportation of residents.										11
12	Mr. Rand and Mr. Dillon are not a members of the Health, Public Safety and Justice Committee Board, which directly oversees Heddington Oaks.										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 Heddington Oaks # 0052357 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 Peoria County
Street Address Room 501, Peoria County Courthouse
City / State / Zip Code Peoria, IL 61602
Phone Number (309) 672-6056
Fax Number (309) 672-6065

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	County Board & Administration	Direct allocation per	1		\$	\$		21,983	1
2	19	County Auditor	Maximus, Inc. Please	1					9,928	2
3	19	Finance	see attached schedule.	1					221,453	3
4	19	Information Technology	Further detail	1					471,866	4
5	19	State's Attorney	available upon	1					55,533	5
6	21	Human Resources	request.	1					66,891	6
7	22	Employee Benefits - U/C		1					2,648	7
8	22	Employee Benefits-Work Comp		1					50,183	8
9	22	Employee Benefits - Health		1					189,725	9
10	30	Depreciation - Equip & Vehicle		1					15,975	10
11										11
12										12
13	22	IMRF	Direct Cost						780,709	13
14	22	FICA	Direct Cost						502,409	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		2,389,302	25

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	Bond		X	New Facility	N/A	10/03/11	\$ 42,000,000	\$ 41,600,000	12/15/2041	0.0468	\$ 1,893,405	1
2	Bond Premium		X	New Facility	N/A	10/03/11	585,168	541,822	12/15/2041	0.0468	(21,673)	2
3												3
4												4
5												5
	Working Capital											
6	Peoria County	X		New Facility	33,976.68	6/30/2014	3,500,000	2,557,095	12/30/2023	0.0300	84,014	6
7												7
8												8
9	TOTAL Facility Related				\$33,976.68		\$ 46,085,168	\$ 44,698,917			\$ 1,955,746	9
	B. Non-Facility Related*											
10												10
11												11
12							Less: Interest Income Offset				(35,492)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (35,492)	14
15	TOTALS (line 9+line14)						\$ 46,085,168	\$ 44,698,917			\$ 1,920,254	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* 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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		2015		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2016 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.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012	N/A	9	
		2013		10	
		2014		11	
		2015		12	
County facility-pays no real estate tax.				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heddington Oaks COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052357

CONTACT PERSON REGARDING THIS REPORT Randy Brunner

TELEPHONE (309) 677-6233 FAX #: (309) 495-4608

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.	County facility- pays no real estate tax.	\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 N/A 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	147,086	B. General Construction Type:	Exterior	Masonry/Hardy Board	Frame	Steel	Number of Stories	Two
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C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	14.23 Acres	2011	\$ 821,267	1
2					2
3	TOTALS	#VALUE!		\$ 821,267	3

Facility Name & ID Number Hedddington Oaks

0052357

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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	214			2013	\$ 44,104,157	\$ 1,102,604	40	\$ 1,102,604	\$	\$ 3,583,463	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks (original)			2013	174,798	8,740	20	8,740		28,405	9
10	Curbs and gutters (original)			2013	101,904	5,095	20	5,095		16,560	10
11	Landscaping (original)			2013	202,800	10,140	20	10,140		32,955	11
12	Concrete paving (original)			2013	480,259	24,013	20	24,013		78,042	12
13											13
14	Laundry Room Structural Improvements			2014	5,600	560	10	560		1,213	14
15	ERV Unit Rework - Mechanical Room			2014	16,000	1,600	10	1,600		3,467	15
16											16
17	Storage Building			2015	155,820	7,791	20	7,791		14,283	17
18	Hill Erosion Repair			2015	19,770	1,977	10	1,977		2,801	18
19											19
20	Muffin Monster Grinder - Located in manhole near SE corner of the facil			2016	93,269	6,995	10	6,995		6,995	20
21	Wall Protection (Rooms B110, B111, B112)			2016	16,544		10				21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Heddington Oaks

0052357

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 45,370,922	\$ 1,169,515		\$ 1,169,515	\$	\$ 3,768,183	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	\$ 1,564,963	\$ 170,485	\$ 170,485	\$ -	5-15	\$ 560,438	71
72	Current Year Purchases	40,126	4,062	4,062	-	5-10	4,062	72
73	Fully Depreciated Assets	101,567	569	569	-	5-15	101,567	73
74	Allocated from Peoria County			15,975	15,975			74
75	TOTALS	\$ 1,706,656	\$ 175,116	\$ 191,091	\$ 15,975		\$ 666,067	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	Facility Maintenance	2012 Ford F-250 4X2	2012	\$ 27,165	\$ 5,433	\$ 5,433	\$ -	5	\$ 23,996	76
77	Resident Transporation	2014 Ford Transport Bus	2014	55,290	11,058	11,058	-	5	32,252	77
78							-			78
79							-			79
80	TOTALS			\$ 82,455	\$ 16,491	\$ 16,491	\$ -		\$ 56,248	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 47,981,300	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,361,122	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,377,097	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,975	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,490,498	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	Facility Branding and Trademark	\$ 59,595	\$ 5,959	\$ 19,369	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 59,595	\$ 5,959	\$ 19,369	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 60,245	92
93			93
94			94
95		\$ 60,245	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: N/A
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. YESNO

		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:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: YESNO Terms: *

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

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$ 41,994Description: Medical Equipment - \$32,338; Duplicating Equipment - \$9,656
(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			\$ N/A	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	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	39(2),(3)	hrs	\$	4,810	\$ 299,305	\$ 931	4,810	\$ 300,236	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,218	71,875		1,218	71,875	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,047	329,476		6,047	329,476	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				253,860		253,860	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					66,876		66,876	12
13	Other (specify): _____									13
14	TOTAL			\$	12,075	\$ 700,656	\$ 321,667	12,075	\$ 1,022,323	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.

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	\$ 1,805,590	\$ 1,805,590	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,050,000)	3,379,441	3,379,441	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,094,314	5,094,314	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	72,879	72,879	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intangible Assets</u>	59,595	59,595	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,411,819	\$ 10,411,819	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	821,267	821,267	13
14	Buildings, at Historical Cost	44,104,157	44,104,157	14
15	Leasehold Improvements, at Historical Cost	1,266,765	1,266,765	15
16	Equipment, at Historical Cost	1,789,111	1,789,111	16
17	Accumulated Depreciation (book methods)	(4,509,867)	(4,490,498)	17
18	Deferred Charges	2,191	2,191	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) <u>CIP</u>	60,245	60,245	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 43,533,869	\$ 43,553,238	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 53,945,688	\$ 53,965,057	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 656,277	\$ 656,277	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,671	284,671	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	83,080	83,080	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	586,932	586,932	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,610,960	\$ 1,610,960	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,557,095	2,557,095	39
40	Mortgage Payable			40
41	Bonds Payable	42,141,822	42,141,822	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)	\$ 44,698,917	\$ 44,698,917	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 46,309,877	\$ 46,309,877	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,635,811	\$ 7,655,180	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 53,945,688	\$ 53,965,057	48

*(See instructions.)

Facility Name: Heddington Oaks
IDPH License ID Number: 0052357
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

			After
	Description	Operating	Consolidation
175-21210	ACCRUED VAC/COMP TIME	268,805	268,805
175-21230	VOLUNTARY SEPARATION PROG	-	-
175-23214	STATE OF ILLINOIS	98,377	98,377
175-25110	DEFERRED PROPERTY TAXES	-	-
175-25210	DEFERRED REVENUE	219,750	219,750
	Total - Line 36	586,932	586,932

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,807,606	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,807,606	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,171,795)	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)	\$ (1,171,795)	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)	\$ 7,635,811	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heddington Oaks

0052357

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 15,647,137	1
2	Discounts and Allowances for all Levels	(3,045,409)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,601,728	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,400,057	6
7	Oxygen	58,412	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,458,469	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	7,784	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,070	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	243,109	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 255,963	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35,492	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,492	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Schedule 19A</u>	2,013,508	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,013,508	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,365,160	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,197,731	31
32	Health Care	6,079,043	32
33	General Administration	2,383,651	33
	B. Capital Expense		
34	Ownership	3,364,822	34
	C. Ancillary Expense		
35	Special Cost Centers	3,046,728	35
36	Provider Participation Fee	464,980	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,536,955	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,171,795)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,171,795)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,235,059	44
45	Private Pay - Net Inpatient Revenue	3,646,768	45
46	Medicare - Net Inpatient Revenue	1,337,137	46
47	Other-(specify) <u>Third Party</u>	382,764	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,601,728	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.

^ - County home. No tax return required.

Facility Name:

Heddington Oaks

IDPH License ID Number:

0052357

Fiscal Year End:

12/31/2016

Schedule 19A

XVII. Income Statement

Line 28a Other Revenue (specify):

	Description	Amount
17561756632-36300	MISCELLANEOUS (UNANTICIPA	-
17561756635-35126	RESTITUTION	1,970
17561756635-36300	MISCELLANEOUS (UNANTICIPA	-
17561756636-34655	MISC. FEES FOR SERVICES	-
17561756638-31110	PROPERTY TAX	2,000,402
17561756638-34700	COPIES	34
17561756638-34951	VENDING MACHINE REVENUE	-
17561756638-36300	MISCELLANEOUS (UNANTICIPA	-
17561756638-54498	RECOVERY OF BAD DEBT	11,102
17561756644-36300	MISCELLANEOUS (UNANTICIPA	-
	Total - Line 28a	2,013,508

Facility Name & ID Number Heddington Oaks# 0052357Report Period Beginning: 01/01/2016Ending: 12/31/2016

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	1,644	2,400	\$ 73,139	\$ 30.48	1
2	Assistant Director of Nursing	1,795	2,196	55,526	25.29	2
3	Registered Nurses	16,615	20,596	540,867	26.26	3
4	Licensed Practical Nurses	54,020	64,619	1,413,606	21.88	4
5	CNAs & Orderlies	148,399	166,022	2,360,715	14.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,775	2,329	54,912	23.58	9
10	Activity Assistants	12,543	14,593	232,373	15.92	10
11	Social Service Workers	4,754	6,170	152,121	24.65	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,329	68,301	29.33	13
14	Head Cook	1,867	2,171	56,334	25.95	14
15	Cook Helpers/Assistants	35,071	42,453	539,832	12.72	15
16	Dishwashers					16
17	Maintenance Workers	3,481	3,866	86,825	22.46	17
18	Housekeepers	20,941	24,380	294,544	12.08	18
19	Laundry	9,094	10,110	104,498	10.34	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,606	21,939	396,583	18.08	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	1,945	2,289	39,146	17.10	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	334,390	388,462	\$ 6,469,323 *	\$ 16.65	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		\$		35
36	Medical Director	Monthly	5,004	9(3)	36
37	Medical Records Consultant	Monthly	2,080	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	570	11(3)	44
45	Social Service Consultant	Monthly	1,374	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,028		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	767	\$ 26,083	10(3)	50
51	Licensed Practical Nurses	11,771	359,854	10(3)	51
52	Certified Nurse Assistants/Aides	16,393	292,338	10(3)	52
53	TOTAL (lines 50 - 52)	28,931	\$ 678,275		53

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Heddington Oaks

0052357

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

\$

N/A

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$

B. Administrative - Other

Description

Amount

Peoria County (Management Fee)

\$ 81,960

Eliminated on P3, L17 C7

Roger Herman - Contracted Interim Adminstrator

119,006

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 200,966

C. Professional Services

Vendor/Payee

Type

Amount

RSM US LLP

Accounting

\$ 13,350

Matthew Koch

Accounting

10,357

Ability Network, Inc.

Data management

4,947

US Bank

Bond Issuance Service Fees

500

Goranson Consulting

Employee assessment

530

Charles H. Foley & Associates, Inc.

Consulting

3,208

HR Fit, LLC

HR assessment and training

9,351

Douglas B Tinch

Accounting - payroll review

1,475

Plante & Moran

Accounting - Payroll review

14,000

Management Performance Associates

Consulting

3,175

Peoria County

Data Processing

556,440

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 617,333

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 50,183

Unemployment Compensation Insurance

2,647

FICA Taxes

502,409

Employee Health Insurance

189,725

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

780,709

Tuition Reimbursement

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,525,673

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 4,077

Advertising: Employee Recruitment

4,468

Health Care Worker Background Check

(Indicate # of checks performed 12)

226

Patient Background Checks

244

4,600

LeadingAge of Illinois

14,484

Miscellaneous Dues & Subscriptions

Miscellaneous Fees

325

Less: Lobbying Dues

(2,897)

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 25,283

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

138

Seminar Expense

464

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 602

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: Heddington Oaks
IDPH License ID Number: 0052357
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Total from Page 21, Section C		617,333
Total (agree to Schedule V, line 19, column 3)		617,333
Allocated from County IT User Fees		(84,574)
Allocated from County Professional Services		286,914
Total (agree to Schedule V, line 19, column 8)		819,673

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. **LeadingAge of Illinois \$14,484**

(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?

N/A

(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?

10 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 104,718

Line 10(2)

(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.

N/A

(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.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 464,980

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.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount. \$ 5,070

(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. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Adequate records have been maintained

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?

N/A

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.

\$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: Baker Tilly

(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.

N/A

Attach invoices and a summary of services for all architect and appraisal fees