

		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: <u>0048157</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heritage Health Bloomington</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>700 East Walnut St</u> <u>Bloomington</u> <u>61701</u>																									
Number City Zip Code																									
County: <u>McLean</u>																									
Telephone Number: <u>(309)827-8044</u> Fax # <u>()</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David M Underwood</u></td></tr><tr><td>(Title) <u>EVP & CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>David M Underwood</u>																								
	(Title) <u>EVP & CFO</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>July 2006</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Dave Underwood</u> Telephone Number: <u>309 823-7135</u>																									
Email Address: _____																									

Facility Name & ID Number Heritage Health Bloomington

0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 3/25/16

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	111	88	34,140	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
111	TOTALS	88	34,140	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,893	12,381	3,759	24,033	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,893	12,381	3,759	24,033	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.40%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/2006

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 and days of care provided 3,759

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Health Bloomington # 0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16
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	253,365	16,159		269,524		269,524	4,603	274,127			1
2	Food Purchase		176,631		176,631		176,631		176,631			2
3	Housekeeping	109,426	31,039		140,465		140,465	33	140,498			3
4	Laundry	69,200	15,229		84,429		84,429		84,429			4
5	Heat and Other Utilities			104,323	104,323		104,323	1,430	105,753			5
6	Maintenance	101,543	37,436	109,357	248,336		248,336	19,261	267,597			6
7	Other (specify):*											7
8	TOTAL General Services	533,534	276,494	213,680	1,023,708		1,023,708	25,327	1,049,035			8
	B. Health Care and Programs											
9	Medical Director			15,828	15,828		15,828		15,828			9
10	Nursing and Medical Records	2,009,298	209,451	63,251	2,282,000		2,282,000	(21,272)	2,260,728			10
10a	Therapy		904,722	62,434	967,156	(966,884)	272		272			10a
11	Activities	62,813	2,647		65,460		65,460		65,460			11
12	Social Services	69,654		441	70,095		70,095		70,095			12
13	CNA Training							1,134	1,134			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,141,765	1,116,820	141,954	3,400,539	(966,884)	2,433,655	(20,138)	2,413,517			16
	C. General Administration											
17	Administrative	88,000			88,000		88,000		88,000			17
18	Directors Fees											18
19	Professional Services			324,244	324,244		324,244	(294,208)	30,036			19
20	Dues, Fees, Subscriptions & Promotions			229,925	229,925	(175,463)	54,462	(24,620)	29,842			20
21	Clerical & General Office Expenses	222,527	27,390	25,247	275,164		275,164	268,814	543,978			21
22	Employee Benefits & Payroll Taxes			537,871	537,871		537,871	36,278	574,149			22
23	Inservice Training & Education			13,961	13,961		13,961	1,112	15,073			23
24	Travel and Seminar			6,755	6,755		6,755	(1,756)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,651	62,651		62,651	15,219	77,870			26
27	Other (specify):* Lost resident items			(36,448)	(36,448)		(36,448)	36,469	21			27
28	TOTAL General Administration	310,527	27,390	1,164,206	1,502,123	(175,463)	1,326,660	37,308	1,363,968			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,985,826	1,420,704	1,519,840	5,926,370	(1,142,347)	4,784,023	42,497	4,826,520			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							588,784	588,784			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,086	40,086		40,086	136,539	176,625			32
33	Real Estate Taxes							88,973	88,973			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(484,070)	2,110			34
35	Rent-Equipment & Vehicles			17,658	17,658		17,658	8,193	25,851			35
36	Other (specify):*											36
37	TOTAL Ownership			543,924	543,924		543,924	338,419	882,343			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			803,125	803,125	966,884	1,770,009	(358,204)	1,411,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					175,463	175,463		175,463			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			803,125	803,125	1,142,347	1,945,472	(358,204)	1,587,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,985,826	1,420,704	2,866,889	7,273,419		7,273,419	22,712	7,296,131			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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(3,326)			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	(1,363)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,499)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,542)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	36,469			24
25	Fund Raising, Advertising and Promotional	(33,406)			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)	\$ (14,667)		\$	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)	37,379		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,379		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 22,712		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.			\$		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

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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(5,542)	19	22
23				23
24		36,469	27	24
25		(33,406)	20	25
26				26
27		(3,326)	34	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	(5,805)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Bloomington# 0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	4,603	0	0	0	0	0	0	0	0	4,603	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	33	0	0	0	0	0	0	0	0	33	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,430	0	0	0	0	0	0	0	0	1,430	5
6	Maintenance	0	0	19,261	0	0	0	0	0	0	0	0	19,261	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	25,327	0	0	0	0	0	0	0	0	25,327	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	(21,554)	282	0	0	0	0	0	0	0	0	(21,272)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,134	0	0	0	0	0	0	0	0	1,134	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	(21,554)	1,416	0	0	0	0	0	0	0	0	(20,138)	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	(5,542)	(306,315)	17,649	0	0	0	0	0	0	0	0	(294,208)	19
20	Fees, Subscriptions & Promotions	(33,406)	0	8,786	0	0	0	0	0	0	0	0	(24,620)	20
21	Clerical & General Office Expenses	0	0	268,814	0	0	0	0	0	0	0	0	268,814	21
22	Employee Benefits & Payroll Taxes	0	0	36,278	0	0	0	0	0	0	0	0	36,278	22
23	Inservice Training & Education	0	0	1,112	0	0	0	0	0	0	0	0	1,112	23
24	Travel and Seminar	(7,499)	0	5,743	0	0	0	0	0	0	0	0	(1,756)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	15,219	0	0	0	0	0	0	0	0	15,219	26
27	Other (specify):*	36,469	0	0	0	0	0	0	0	0	0	0	36,469	27
28	TOTAL General Administration	(9,978)	(306,315)	353,601	0	0	0	0	0	0	0	0	37,308	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,978)	(327,869)	380,344	0	0	0	0	0	0	0	0	42,497	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	563,755	0	25,029	0	0	0	0	0	0	0	588,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,363)	137,633	0	269	0	0	0	0	0	0	0	136,539	32
33	Real Estate Taxes	0	88,973	0	0	0	0	0	0	0	0	0	88,973	33
34	Rent-Facility & Grounds	(3,326)	(486,180)	0	5,436	0	0	0	0	0	0	0	(484,070)	34
35	Rent-Equipment & Vehicles	0	0	0	8,193	0	0	0	0	0	0	0	8,193	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,689)	304,181	0	38,927	0	0	0	0	0	0	0	338,419	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	(358,204)	0	0	0	0	0	0	0	0	0	(358,204)	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	(358,204)	0	0	0	0	0	0	0	0	0	(358,204)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,667)	(381,892)	380,344	38,927	0	0	0	0	0	0	0	22,712	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
Heritage Enterprises, Inc.	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (21,554)	\$ (21,554)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy				2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		(358,204)	(358,204)	3
4	V	19	Adjustment for Related Organization	306,315	Heritage Operations Group, LLC			(306,315)	4
5	V								5
6	V	34	Adjustment for Related Organization	486,180	Heritage Manor Real Estate, LLC			(486,180)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		88,973	88,973	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		130,215	130,215	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		563,755	563,755	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		7,418	7,418	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 792,495			\$ 410,603	\$ * (381,892)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Operations Group		\$	4,603	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					33	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,430	19
20	V	6	Maintenance					19,261	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					282	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,134	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					17,649	31
32	V	20	Fees, Subscription, Promotions					8,786	32
33	V	21	Clerical & General Office Expenses					268,814	33
34	V	22	Employee Benefits & Payroll Taxes					36,278	34
35	V	23	Inservice Training & Education					1,112	35
36	V	24	Travel and Seminar					5,743	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					15,219	38
39	Total			\$			\$ 0	\$ * 380,344	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					25,029	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					269	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,436	20
21	V	35	Rent-Equipment & Vehicles					8,193	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					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	\$ * 38,927	39

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

Facility Name & ID Number Heritage Health Bloomington# 0048157

Report Period Beginning:

01/01/16Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	88	\$ 4,603	1
2	2	Food Purchase	Beds	2,571	26	0	0	88	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	88	33	3
4	4	Laundry	Beds	2,571	26	0	0	88	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	88	1,430	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	88	19,261	6
7	7	Other	Beds	2,571	26	0	0	88	0	7
8	9	Medical Director	Beds	2,571	26	0	0	88	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	88	282	9
10	11	Activities	Beds	2,571	26	0	0	88	0	10
11	12	Social Service	Beds	2,571	26	0	0	88	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	88	1,134	12
13	14	Program Transportation	Beds	2,571	26	0	0	88	0	13
14	15	Other	Beds	2,571	26	0	0	88	0	14
15	17	Administrative	Beds	2,571	26	0	0	88	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	88	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	88	17,649	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	88	8,786	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	88	268,814	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	88	36,278	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	88	1,112	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	88	5,743	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	88	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	88	15,219	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 380,344	25

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 See Pg 8
Street Address _____
City / State / Zip Code _____
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	\$		88	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		88	25,029	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			88		3
4	32	Interest	Beds	2,571	26	7,851		88	269	4
5	33	Real Estate Taxes	Beds	2,571	26			88		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		88	5,436	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		88	8,193	7
8	36	Other	Beds	2,571	26			88		8
9	38	Medically Nec Transportation	Beds	2,571	26			88		9
10	39	Ancillary Service Centers	Beds	2,571	26			88		10
11	40	Barber and Beauty Shops	Beds	2,571	26			88		11
12	41	Coffee and Gift Shops	Beds	2,571	26			88		12
13	42	Other	Beds	2,571	26			88		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					\$ 1,137,301	\$		\$ 38,927	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	Bank of America		x	Mortgage			\$				\$	130,215	1
2	Bank of America		x	Loan Fee Amortization								7,418	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x	Working Capital								40,086	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	177,719	9
	B. Non-Facility Related*												
10	Interest Income											(1,363)	10
11													11
12	Allocated Corporate											269	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(1,094)	14
15	TOTALS (line 9+line14)						\$				\$	176,625	15

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

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

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

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

B. Real Estate Taxes

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.)				\$88,973	2
3. Under or (over) accrual (line 2 minus line 1).				\$88,973	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.				\$88,973	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	81,020	8	
		2012	81,153	9	
		2013	84,744	10	
		2014	86,147	11	
		2015	88,973	12	
		FOR BHF USE ONLY			
		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.

FACILITY NAME Heritage Health Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

38,544

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 255,078	1
2					2
3	TOTALS			\$ 255,078	3

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	88				\$ 560,548	\$		\$	\$	\$	4
5					221,147						5
6											6
7											7
8											8
	Improvement Type**										
9	1978 Improvements		1978		14,607						9
10	1979 Improvements		1979		95,460						10
11	1980 Improvements		1980		75,591						11
12	1981 Improvements		1981		11,544						12
13	1982 Improvements		1982		9,256						13
14	1983 Improvements		1983		13,130						14
15	1984 Improvements		1984		7,215						15
16	1985 Improvements		1985		45,885						16
17	1986 Improvements		1986		13,469						17
18	1988 Improvements		1988		83,109						18
19	1989 Improvements		1989		2,439						19
20	1990 Improvements		1990		30,676						20
21	1991 Improvements		1991		4,207						21
22	1992 Improvements		1992		1,208						22
23	1993 Improvements		1993		97,303						23
24	1994 Improvements		1994		29,638						24
25	1995 Improvements		1995		121,304						25
26	BOILER		1996		17,850						26
27	EXHAUST HOOD		1996		1,075						27
28	CODE ALERT		1996		1,852						28
29	PHONE SYSTEM		1996		2,339						29
30	INTERIOR REMODEL		1996		103,103						30
31											31
32											32
33											33
34	C/O Allocation					25,029		25,029			34
35	Book Depreciation					401,319		401,319			35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Interior Rehab--paint, wallpaper, remodel facility	1997	\$ 211,945	\$		\$	\$	\$	37
38 Remodel Physical Therapy	1997	43,069						38
39 Disposal Unit--Kitchen	1997	1,439						39
40 Code Alert System	1997	1,997						40
41 Kitchen Remodel	1997	766						41
42								42
43 Code Alert/Nurse Call System	1998	3,654						43
44 Kitchen Remodel	1998	4,166						44
45 Remodel Physical Therapy	1998	1,813						45
46 Addition--Materials	1998	13,431						46
47 Addition--Professional Fees	1998	109,885						47
48								48
49 Addition--Materials	1999	1,155,066						49
50 Addition--Professional Fees	1999	22,035						50
51 Steam Table Hood	1999	3,821						51
52 ALTA Survey	1999	2,434						52
53 Dish Washing Area	1999	4,083						53
54 Sewage Pump	1999	2,492						54
55 Parking Lot Pavement	1999	6,743						55
56								56
57 Dayroom Light Fixtures	2000	6,189						57
58 Door Kickplates	2000	2,991						58
59 Storm windows	2000	4,011						59
60 Addition--Materials	2000	12,770						60
61 Addition--Professional Fees	2000	5,893						61
62 Roof Repair	2000	5,510						62
63 Adj to Capital Report	2000	(2,383)						63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,187,775	\$ 426,348		\$ 426,348	\$	\$	70

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

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,187,775	\$ 426,348		\$ 426,348	\$	\$	1
2 <u>Paging System</u>	2001	2,456						2
3 <u>Alarm Door/Lock</u>	2001	1,950						3
4 <u>Code Alert</u>	2001	3,965						4
5 <u>Electrical Wiring for A/C Unit</u>	2001	1,805						5
6 <u>Main Water Meter</u>	2001	2,000						6
7 <u>Valves Boiler Unit</u>	2001	1,883						7
8								8
9 <u>Smoke Detectors and Installation</u>	2002	14,551						9
10 <u>Mixing valve</u>	2002	1,862						10
11 <u>Main Corridor Rehab (Wallcovering)</u>	2002	3,885						11
12 <u>Floor Tile</u>	2002	1,280						12
13 <u>Kitchen</u>	2002	957						13
14 <u>Roof Repair</u>	2002	5,283						14
15								15
16 <u>Smoke Detectors and Installation</u>	2003	5,970						16
17 <u>Roof Replacement</u>	2003	111,250						17
18 <u>Sprinklers</u>	2003	31,119						18
19 <u>Parking Lot</u>	2003	3,862						19
20 <u>Ceramic Tile</u>	2003	1,315						20
21 <u>Compressor</u>	2003	3,898						21
22 <u>Wallpaper</u>	2003	857						22
23 <u>Maglock Keypad</u>	2003	2,762						23
24 <u>ANSUL Fire Surpression</u>	2003	1,450						24
25 <u>Fire Escape Remodel</u>	2003	2,003						25
26 <u>Adj to Capital Report</u>	2003	(14,958)						26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,379,180	\$ 426,348		\$ 426,348	\$	\$	34

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

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,379,180	\$ 426,348		\$ 426,348	\$	\$	1
2 Sewage Pump	2004	3,823						2
3 Nurses Station A/C	2004	1,478						3
4 Fire Alarm	2004	2,825						4
5 Sealcoat Parking Lot	2004	1,646						5
6 Storm Windows	2004	645						6
7 Window A/C (8)	2004	6,030						7
8 Ceiling Repairs	2004	4,011						8
9								9
10 Delayed Egress Latches	2005	12,431						10
11 Mixing valve	2005	1,360						11
12 Paint ceiling	2005	596						12
13 A/C	2005	2,153						13
14 Sidewalk	2005	2,100						14
15								15
16 Plumbing	2006	6,791						16
17 A/C -- Thru wall units	2006	6,900						17
18 Exterior Painting	2006	11,650						18
19 Compressor	2006	5,015						19
20 Condensing Unit	2006	4,902						20
21 Insinkerator	2006	2,350						21
22 Water Softener	2006	27,469						22
23 Basement De-watering	2006	3,750						23
24 Paint Kitchen	2006	1,820						24
25 Repair building	2006	1,199						25
26 Landscaping	2006	1,335						26
27 Pump Motor	2006	1,072						27
28 Mixing valve	2006	2,884						28
29 Adj to Capital Report	2006	(722)						29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,494,693	\$ 426,348		\$ 426,348	\$	\$	34

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

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 3,494,693	\$ 426,348		\$ 426,348	\$	\$	1
2 Resident Rooms Remodel -- Paint and flooring	2007	13,957						2
3 Sprinkler	2007	1,152						3
4 Compressor	2007	4,006						4
5 Condensor	2007	2,250						5
6 Water Heater	2007	7,359						6
7 Therapy Room Remodel-- Paint & Flooring	2007	2,527						7
8 Window treatments	2007	583						8
9 Cooler	2007	642						9
10 Boiler	2007	4,803						10
11 Adj to Capital Report	2007	(8,178)						11
12 Heat/Cool Units	2008	5,420						12
13 Replace Fire Escape	2008	13,577						13
14 Schematic Design (Architect Fees) Facility Renovation	2008	26,038						14
15 Water Heater --Backflow	2008	4,926						15
16 Fire Alarm	2008	63,563						16
17 Water Heater	2008	6,057						17
18 Adj to Capital Report	2008	(19,981)						18
19 HVAC Unit	2009	7,035						19
20 Compressor	2009	4,658						20
21 HVAC Renovation: Boilers, ducts, hvac units & labor	2009	360,549						21
22 Windows	2009	148,790						22
23								23
24 HVAC Renovation: Boilers, ducts, hvac units & labor	2010	15,355						24
25 Architect, engineering fees	2010	87,978						25
26 trane compressor	2010	6,255						26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,254,014	\$ 426,348		\$ 426,348	\$	\$	34

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

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
1	Totals from Page 12D, Carried Forward		\$ 4,254,014	\$ 426,348		\$ 426,348	\$	\$	1
2									2
3	<u>Signage</u>	2011	9,969						3
4									4
5	<u>PT Addition 2010 & 2011 - Contracted Total</u>	2011	1,604,828						5
6	<u>PT Addition 2010 & 2011 - Capitalized Interest</u>	2011	7,278						6
7	<u>Renovation 2010 & 2011 - Contracted Total</u>	2011	2,381,723						7
8	<u>Renovation 2010 & 2011 - Capitalized Interest</u>	2011	15,565						8
9	<u>Renovation 2010 & 2011 - Third Party Costs:</u>								9
10	<u>Architect</u>	2011	44,486						10
11	<u>Asbestos</u>	2011	99,441						11
12	<u>Construction Certificate Consultant</u>	2011	6,150						12
13	<u>Elevator</u>	2011	4,000						13
14	<u>Engineer</u>	2011	9,238						14
15	<u>Landscaping</u>	2011	17,814						15
16	<u>Legal/Plan Review</u>	2011	12,720						16
17	<u>Plumbing</u>	2011	10,340						17
18	<u>Signage, Electric,HVAC & Supplies</u>	2011	4,352						18
19	<u>Sitework</u>	2011	3,795						19
20	<u>Technology</u>	2011	321,596						20
21	<u>Window Coverings</u>	2011	5,295						21
22									22
23	<u>PT Addition (Additional Costs) - Signage</u>	2012	2,213						23
24	<u>Renovation (Additional Costs)</u>								24
25	<u>Architect</u>	2012	749						25
26	<u>Asbestos</u>	2012	16,910						26
27	<u>Landscaping</u>	2012	70,935						27
28	<u>Plumbing</u>	2012	1,325						28
29	<u>Signage, Electric,HVAC & Supplies</u>	2012	6,275						29
30	<u>Technology</u>	2012	60,097						30
31	<u>Window Coverings</u>	2012	27,483						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,998,591	\$ 426,348		\$ 426,348	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 8,998,591	\$ 426,348		\$ 426,348	\$	\$	1
2								2
3 Nurse Master Console	2012	5,031						3
4								4
5 Replacement- sprinkler heads, floor tile & countertop-1 Rm.	2013	10,395						5
6								6
7 Elevator Power Unit Replacement	2013	11,425						7
8 Point of Care Kiosk Cabling	2013	7,985						8
9 Air conditioning units - new	2013	3,646						9
10								10
11 Final Charge - Elevator Power Replacement	2014	8,275						11
12 Install 9 PTAC Units	2014	3,834						12
13 Elevator Upgrades-Code Requirements	2014	10,153						13
14 Install Split Replacement Systems - Rooms 129 and 130	2014	18,566						14
15 Parking Lot Upgrades	2014	10,025						15
16 Replace Sewage Ejection Pump	2014	6,146						16
17								17
18 Install (6) PTAC units	2015	2,730						18
19 Replaced east dining room compressor	2015	3,685						19
20 Replace sewage ejection pump	2015	4,406						20
21								21
22 Install 5T condensing unit	2016	3,802						22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 9,108,695	\$ 426,348		\$ 426,348	\$	\$	34

**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	\$2,264,401	\$162,436	\$162,436	\$		\$	71
72	Current Year Purchases	28,651						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,293,052	\$162,436	\$162,436	\$		\$	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	11,656,825
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	588,784
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	588,784
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: \$ 17,658 Description: Televisions and copiers
(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	None		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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		hrs	\$		\$	334,812	\$		\$	334,812	1			
2	Licensed Speech and Language Development Therapist		hrs				96,815				96,815	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist		hrs				371,498	272			371,770	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation		hrs									8			
9	Pharmacy		# of prescrpts					904,450			904,450	9			
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)														
10			hrs									10			
11	Academic Education		hrs									11			
12	Other (specify):											12			
13	Other (specify):						62,434				62,434	13			
14	TOTAL			\$		\$	865,559	\$	904,722	\$	1,770,281	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	\$ 400	\$	1
2	Cash-Patient Deposits	8,158		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,040,507		3
4	Supply Inventory (priced at)	12,753		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,453		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,390,192)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,297,921)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,297,921)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 258,431	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,158		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,091		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,511		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	20,480		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 570,671	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 570,671	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,868,592)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,297,921)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,901,936)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,901,936)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,344	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)	\$ 33,344	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)	\$ (1,868,592)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Bloomington

0048157

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 6,508,064	1
2	Discounts and Allowances for all Levels	(3,840,002)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,668,062	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,865,501	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,865,501	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	1,899	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,326	16
17	Sale of Drugs	1,766,352	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	260	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,771,837	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,363	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,363	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,306,763	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,023,708	31
32	Health Care	3,400,539	32
33	General Administration	1,502,123	33
	B. Capital Expense		
34	Ownership	543,924	34
	C. Ancillary Expense		
35	Special Cost Centers	803,125	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)*	\$ 7,273,419	40
41	Income before Income Taxes (line 30 minus line 40)**	33,344	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 33,344	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.

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	1,668	1,756	\$ 67,436	\$ 38.40	1
2	Assistant Director of Nursing	1,505	1,584	49,059	30.97	2
3	Registered Nurses	15,304	16,109	518,171	32.17	3
4	Licensed Practical Nurses	16,658	17,536	455,186	25.96	4
5	CNAs & Orderlies	56,238	59,198	879,319	14.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,431	1,506	40,127	26.64	8
9	Activity Director					9
10	Activity Assistants	4,761	5,012	62,813	12.53	10
11	Social Service Workers	3,493	3,677	69,654	18.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,815	19,806	253,365	12.79	15
16	Dishwashers					16
17	Maintenance Workers	5,436	5,722	101,543	17.75	17
18	Housekeepers	8,579	9,031	109,426	12.12	18
19	Laundry	5,094	5,362	69,200	12.91	19
20	Administrator	1,984	2,088	88,000	42.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,887	7,249	222,527	30.70	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)	147,853	155,636	\$ 2,985,826 *	\$ 19.18	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		\$ 0		35
36	Medical Director		15,828		36
37	Medical Records Consultant		37,840		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,262		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		441		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 58,371		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 16,230		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		\$ 16,230		53

Facility Name & ID Number <u>Heritage Health Bloomington</u>	STATE OF ILLINOIS # <u>0048157</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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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. HCCI

(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 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 175,463
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,900

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? _____
 Firm Name: Sulaski & Webb

(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 Bloomington LLC
HFS ID# 203904134001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>		
Provider Participation Fee - \$1.50	Line 20, Col 3	(51,210)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(124,253)
		<u>(175,463)</u>
Provider Participation Fee	Line 42	<u>175,463</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(904,450)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(62,434)
		<u>(966,884)</u>
Ancillary Service Centers	Line 39	<u>966,884</u>