

		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: 0048090

Facility Name: Heritage Health Peru

Address: 1301 21st Street Peru 61354
Number City Zip Code

County: LaSalle

Telephone Number: (815) 223-4901 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Dave Underwood Telephone Number: 309 823-7135
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 01/01/16 to 12/31/16 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) David M Underwood
(Title) EVP & CFO

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

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

Facility Name & ID Number Heritage Health Peru

0048090 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 <u>3/25/16</u>					
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	<u>129</u>	Skilled (SNF)	<u>127</u>	<u>46,650</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>129</u>	TOTALS	<u>127</u>	<u>46,650</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,544</u>	<u>6,415</u>	<u>5,051</u>	<u>38,010</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,544</u>	<u>6,415</u>	<u>5,051</u>	<u>38,010</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.48%

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 5,051

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Health Peru # 0048090 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	246,439	15,074		261,513		261,513	6,643	268,156			1
2	Food Purchase		241,284		241,284		241,284		241,284			2
3	Housekeeping	60,495	41,723		102,218		102,218	48	102,266			3
4	Laundry	104,264	9,266		113,530		113,530		113,530			4
5	Heat and Other Utilities			113,703	113,703		113,703	2,064	115,767			5
6	Maintenance	129,027	72,705	99,833	301,565		301,565	27,797	329,362			6
7	Other (specify):*											7
8	TOTAL General Services	540,225	380,052	213,536	1,133,813		1,133,813	36,552	1,170,365			8
	B. Health Care and Programs											
9	Medical Director			31,995	31,995		31,995		31,995			9
10	Nursing and Medical Records	2,767,511	208,656	8,986	2,985,153		2,985,153	(27,090)	2,958,063			10
10a	Therapy		764,793	59,806	824,599	(824,445)	154		154			10a
11	Activities	152,023	1,117		153,140		153,140		153,140			11
12	Social Services	52,815		3,675	56,490		56,490		56,490			12
13	CNA Training							1,637	1,637			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,972,349	974,566	104,462	4,051,377	(824,445)	3,226,932	(25,453)	3,201,479			16
	C. General Administration											
17	Administrative	89,847			89,847		89,847		89,847			17
18	Directors Fees											18
19	Professional Services			387,869	387,869		387,869	(360,473)	27,396			19
20	Dues, Fees, Subscriptions & Promotions			303,062	303,062	(246,485)	56,577	(29,019)	27,558			20
21	Clerical & General Office Expenses	349,462	19,773	27,512	396,747		396,747	387,947	784,694			21
22	Employee Benefits & Payroll Taxes			685,591	685,591		685,591	52,356	737,947			22
23	Inservice Training & Education			6,621	6,621		6,621	1,605	8,226			23
24	Travel and Seminar			7,672	7,672		7,672	(2,673)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,905	55,905		55,905	21,963	77,868			26
27	Other (specify):*			155,633	155,633		155,633	(155,633)				27
28	TOTAL General Administration	439,309	19,773	1,629,865	2,088,947	(246,485)	1,842,462	(83,927)	1,758,535			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,951,883	1,374,391	1,947,863	7,274,137	(1,070,930)	6,203,207	(72,828)	6,130,379			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							342,752	342,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,850	61,850		61,850	106,666	168,516			32
33	Real Estate Taxes							50,571	50,571			33
34	Rent-Facility & Grounds			565,020	565,020		565,020	(557,175)	7,845			34
35	Rent-Equipment & Vehicles			18,126	18,126		18,126	11,825	29,951			35
36	Other (specify):*											36
37	TOTAL Ownership			644,996	644,996		644,996	(45,361)	599,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			844,975	844,975	824,445	1,669,420	(193,133)	1,476,287			39
40	Barber and Beauty Shops			1,286	1,286		1,286		1,286			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					246,485	246,485		246,485			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			846,261	846,261	1,070,930	1,917,191	(193,133)	1,724,058			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,951,883	1,374,391	3,439,120	8,765,394		8,765,394	(311,322)	8,454,072			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				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	(1,732)			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	(10,961)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,673)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(155,633)			24
25	Fund Raising, Advertising and Promotional	(41,698)			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)	\$ (223,697)		\$	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)	(87,625)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (87,625)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (311,322)		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		(13,673)	19	22
23				23
24		(155,633)	27	24
25		(41,698)	20	25
26				26
27		0	22	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	(211,004)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Peru # 0048090 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	6,643	0	0	0	0	0	0	0	0	6,643	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	48	0	0	0	0	0	0	0	0	48	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,064	0	0	0	0	0	0	0	0	2,064	5
6	Maintenance	0	0	27,797	0	0	0	0	0	0	0	0	27,797	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	36,552	0	0	0	0	0	0	0	0	36,552	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	(27,498)	408	0	0	0	0	0	0	0	0	(27,090)	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	1,637	0	0	0	0	0	0	0	0	1,637	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	(27,498)	2,045	0	0	0	0	0	0	0	0	(25,453)	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	(13,673)	(372,270)	25,470	0	0	0	0	0	0	0	0	(360,473)	19
20	Fees, Subscriptions & Promotions	(41,698)	0	12,679	0	0	0	0	0	0	0	0	(29,019)	20
21	Clerical & General Office Expenses	0	0	387,947	0	0	0	0	0	0	0	0	387,947	21
22	Employee Benefits & Payroll Taxes	0	0	52,356	0	0	0	0	0	0	0	0	52,356	22
23	Inservice Training & Education	0	0	1,605	0	0	0	0	0	0	0	0	1,605	23
24	Travel and Seminar	(10,961)	0	8,288	0	0	0	0	0	0	0	0	(2,673)	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	21,963	0	0	0	0	0	0	0	0	21,963	26
27	Other (specify):*	(155,633)	0	0	0	0	0	0	0	0	0	0	(155,633)	27
28	TOTAL General Administration	(221,965)	(372,270)	510,308	0	0	0	0	0	0	0	0	(83,927)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(221,965)	(399,768)	548,905	0	0	0	0	0	0	0	0	(72,828)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Peru # 0048090 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	306,631	0	36,121	0	0	0	0	0	0	0	342,752	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,732)	108,010	0	388	0	0	0	0	0	0	0	106,666	32
33	Real Estate Taxes	0	50,571	0	0	0	0	0	0	0	0	0	50,571	33
34	Rent-Facility & Grounds	0	(565,020)	0	7,845	0	0	0	0	0	0	0	(557,175)	34
35	Rent-Equipment & Vehicles	0	0	0	11,825	0	0	0	0	0	0	0	11,825	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,732)	(99,808)	0	56,179	0	0	0	0	0	0	0	(45,361)	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	(193,133)	0	0	0	0	0	0	0	0	0	(193,133)	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	(193,133)	0	0	0	0	0	0	0	0	0	(193,133)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(223,697)	(692,709)	548,905	56,179	0	0	0	0	0	0	0	(311,322)	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	0.00%	\$ (27,498)	\$ (27,498)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(193,133)	(193,133)	3
4	V	19	Adjustment for Related Organization	372,270	Heritage Operations Group, LLC	0.00%		(372,270)	4
5	V								5
6	V	34	Adjustment for Related Organization	565,020	Heritage Manor Real Estate, LLC	0.00%		(565,020)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		50,571	50,571	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		103,382	103,382	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		306,631	306,631	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,628	4,628	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 937,290			\$ 244,581	\$ * (692,709)	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		\$	\$ 6,643	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					48	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					2,064	19
20	V	6	Maintenance					27,797	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					408	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,637	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					25,470	31
32	V	20	Fees, Subscription, Promotions					12,679	32
33	V	21	Clerical & General Office Expenses					387,947	33
34	V	22	Employee Benefits & Payroll Taxes					52,356	34
35	V	23	Inservice Training & Education					1,605	35
36	V	24	Travel and Seminar					8,288	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					21,963	38
39	Total			\$			\$ 0	\$ * 548,905	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					36,121	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					388	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					7,845	20
21	V	35	Rent-Equipment & Vehicles					11,825	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	\$ * 56,179	39

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Peru# 0048090

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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	127	\$ 6,643	1
2	2	Food Purchase	Beds	2,571	26	0	0	127	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	127	48	3
4	4	Laundry	Beds	2,571	26	0	0	127	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	127	2,064	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	127	27,797	6
7	7	Other	Beds	2,571	26	0	0	127	0	7
8	9	Medical Director	Beds	2,571	26	0	0	127	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	127	408	9
10	11	Activities	Beds	2,571	26	0	0	127	0	10
11	12	Social Service	Beds	2,571	26	0	0	127	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	127	1,637	12
13	14	Program Transportation	Beds	2,571	26	0	0	127	0	13
14	15	Other	Beds	2,571	26	0	0	127	0	14
15	17	Administrative	Beds	2,571	26	0	0	127	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	127	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	127	25,470	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	127	12,679	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	127	387,947	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	127	52,356	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	127	1,605	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	127	8,288	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	127	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	127	21,963	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 548,905	25

Facility Name & ID Number Heritage Health Peru # 0048090 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	\$		127	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		127	36,121	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			127		3
4	32	Interest	Beds	2,571	26	7,851		127	388	4
5	33	Real Estate Taxes	Beds	2,571	26			127		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		127	7,845	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		127	11,825	7
8	36	Other	Beds	2,571	26			127		8
9	38	Medically Nec Transportation	Beds	2,571	26			127		9
10	39	Ancillary Service Centers	Beds	2,571	26			127		10
11	40	Barber and Beauty Shops	Beds	2,571	26			127		11
12	41	Coffee and Gift Shops	Beds	2,571	26			127		12
13	42	Other	Beds	2,571	26			127		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	\$		\$ 56,179	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			\$		\$			\$	103,382	1					
2	Bank of America		x	Loan Fee Amortization									4,628	2					
3														3					
4														4					
5														5					
	Working Capital																		
6	Bank of America		x	Working Capital									61,850	6					
7														7					
8														8					
9	TOTAL Facility Related						\$		\$				\$	169,860	9				
	B. Non-Facility Related*																		
10	Interest Income												(1,732)	10					
11														11					
12	Allocated Corporate												388	12					
13														13					
14	TOTAL Non-Facility Related						\$		\$				\$	(1,344)	14				
15	TOTALS (line 9+line14)						\$		\$				\$	168,516	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.)				\$50,571	2
3. Under or (over) accrual (line 2 minus line 1).				\$50,571	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.				\$50,571	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	46,774	8	
		2012	47,738	9	
		2013	48,642	10	
		2014	49,486	11	
		2015	50,571	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 Peru	COUNTY	LaSalle
---------------	----------------------	--------	---------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 17-09-312-013		\$ 2,480.96	\$ 2,481.00
2. 17-09-312-014		\$ 48,090.42	\$ 48,090.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 50,571.38	\$ 50,571.00

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 NO

C. Tax Bills

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:	36,520	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				\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	127				\$ 391,963	\$		\$	\$	4
5					325,293					5
6					153,474					6
7					677,402					7
8										8
	Improvement Type**									
9	1978 Improvements				6,059					9
10	1979 Improvements			1979	9,952					10
11	1980 Improvements			1980	28,648					11
12	1981 Improvements			1981	8,175					12
13	1982 Improvements			1982	39,938					13
14	1983 Improvements			1983	13,985					14
15	1984 Improvements			1985	19,793					15
16	1985 Improvements			1986	550					16
17	1986 Improvements			1987	22,120					17
18	1988 Improvements			1988	19,053					18
19	1989 Improvements			1989	25,453					19
20	1990 Improvements			1990	12,118					20
21	1991 Improvements			1991	19,157					21
22	1992 Improvements			1992	87,224					22
23	1993 Improvements			1993	43,270					23
24	1994 Improvements			1994	16,885					24
25	1995 Improvements			1995	8,377					25
26	WATER SOFTNER			1996	4,550					26
27	AIR CONDITIONER			1996	97					27
28										28
29										29
30										30
31										31
32										32
33	C/O Allocation					36,121		36,121		33
34	Book Depreciation					229,025		229,025		34
35										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 Peru

0048090

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---	1997	\$ 292,864	\$		\$	\$	\$	37
38 Parking Lot Sealer	1997	3,100						38
39 Commercial Disposal	1997	877						39
40								40
41 Water Heater	1998	4,308						41
42 A/C Repair	1998	6,457						42
43 Heater Repair	1998	954						43
44 Laundry Room Remodel	1998	1,450						44
45 Interior Rehab	1998	7,466						45
46								46
47 GFI Outlets	1999	3,420						47
48 Water Meter	1999	1,854						48
49 Roof Replacements	1999	80,498						49
50								50
51 Water Main Break Repair	2000	5,272						51
52 Door Monitor System	2000	9,852						52
53 Patio Improvements	2000	1,310						53
54								54
55 Lennox Condenser	2001	4,527						55
56 Water Heater	2001	3,708						56
57 Sewer Repair	2001	932						57
58								58
59 Sewer Repair	2002	1,267						59
60 Water Heater	2002	4,340						60
61 Ceiling Tiles	2002	110						61
62 Seal Parking Lot	2002	3,100						62
63 Door Lock	2002	1,370						63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,372,572	\$ 265,146		\$ 265,146	\$	\$	70

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

Facility Name & ID Number Heritage Health Peru

0048090

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		\$ 2,372,572	\$ 265,146		\$ 265,146	\$	\$	1
2 Compressor	2003	844						2
3 Shower Room Remodel	2003	4,916						3
4 Back Flow Valve	2003	1,241						4
5 Parking Lot	2003	3,100						5
6 Generator	2003	2,749						6
7 Compressor	2003	939						7
8								8
9								9
10								10
11 Wallguards	2004	22,275						11
12								12
13 Carpet		7,174						13
14								14
15 Ansul System	2005	1,685						15
16 Heat Exchanger	2005	1,800						16
17 Wall hvac	2005	959						17
18 Wallguards	2005	2,313						18
19 A/C condensing unit	2005	4,078						19
20 Exterior Door	2005	17,485						20
21 Solarium	2005	3,812						21
22 Lennox	2005	5,950						22
23 Shower Room Remodel	2005	5,588						23
24 Window Replacement	2005	55,419						24
25 Parking Lot Sealer	2005	3,940						25
26 Disposal	2005	1,303						26
27 Courtyard Door	2005	1,354						27
28 various adjustments	2005	(22,516)						28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,498,980	\$ 265,146		\$ 265,146	\$	\$	34

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

Facility Name & ID Number Heritage Health Peru

0048090

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 12B, Carried Forward		\$ 2,498,980	\$ 265,146		\$ 265,146	\$	\$	1
2	Code Alert	2006	7,226						2
3	Windows	2006	876						3
4	Exterior Door	2006	2,620						4
5	Chimney	2006	6,250						5
6	Boiler	2006	3,002						6
7	Garbage Disposal	2006	1,072						7
8	Sprinklers	2006	34,076						8
9	Heat Pump	2006	1,073						9
10	2006 adj	2006	(918)						10
11	Sprinkler System	2007	189,741						11
12	Water Heater	2007	11,400						12
13	Sewer	2007	3,394						13
14	HVAC	2007	70,422						14
15	Gazebo	2007	4,750						15
16	PTAC Unit	2007	2,720						16
17	Wander Guard	2007	3,129						17
18	2007 adj	2007	(12,899)						18
19	Condensor	2007	14,138						19
20	2008 adj	2008	(8,200)						20
21	Water Main	2008	30,831						21
22	Resident Room Plumbing	2008	12,661						22
23	Parking Lot Repairs	2008	5,221						23
24	Water Softener	2008	9,748						24
25	Water Heater	2008	9,120						25
26	Nurse Call & Phone system	2009	217,290						26
27	Water Pipe	2009	16,750						27
28	Condensing Unit	2009	3,334						28
29									29
30	Plumbing	2009	4,295						30
31	Concrete Ramp	2009	3,150						31
32	Water Heater	2009	6,750						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,152,002	\$ 265,146		\$ 265,146	\$	\$	34

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

Facility Name & ID Number Heritage Health Peru

0048090

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,152,002	\$ 265,146		\$ 265,146	\$	\$	1
2	The following items relate to the rehab of all wings, resident rooms and central								2
3	common area spaces performed by DS Renovations, LLC								3
4	General Conditions & Demolition	2009	89,600						4
5	Carpentry & Millwork	2009	251,225						5
6	Acoustical Ceiling & Flooring	2009	150,757						6
7	Painting	2009	56,514						7
8	Plumbing	2009	30,679						8
9	Electrical	2009	88,804						9
10	HVAC	2009	43,648						10
11	Overhead & Profit	2009	31,594						11
12									12
13	Environmental & Engineering	2009	12,958						13
14									14
15	Exhaust Fan	2010	12,795						15
16	Landscaping	2010	31,701						16
17	Parking Lot	2010	46,950						17
18	DS Renovations, LLC								18
19	General Conditions & Demolition	2010	41,507						19
20	Carpentry & Millwork	2010	77,921						20
21	Acoustical Ceiling & Flooring	2010	29,947						21
22	Painting	2010	75,786						22
23	Plumbing	2010	27,465						23
24	Electrical	2010	42,154						24
25	HVAC	2010	21,347						25
26	Overhead & Profit	2010	16,506						26
27	Contingency & change orders	2010	45,238						27
28									28
29	Interior Design - Renovation Project	2010	6,000						29
30	Plaster/window/shelving (PMSI Construction)	2010	19,170						30
31	Asbestos Abatement	2010	189,525						31
32	Direct supply Window treatments, bed spreads	2010	38,949						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,630,742	\$ 265,146		\$ 265,146	\$	\$	34

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

Facility Name & ID Number Heritage Health Peru

0048090

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 12D, Carried Forward		\$ 4,630,742	\$ 265,146		\$ 265,146	\$	\$	1
2								2
3 Exterior Lights	2011	7,955						3
4 In-sink-erator	2010	2,675						4
5 Air Handler	2011	20,385						5
6 Sign	2011	2,600						6
7 Fire Alarm	2011	8,665						7
8								8
9 Fire Alarm	2012	2,600						9
10 Sprinkler Head	2012	3,464						10
11 Lighting Retrofit	2012	3,255						11
12 Boilers	2012	8,190						12
13								13
14 Condensing Unit	2013	28,841						14
15 Roof Replacement	2013	152,428						15
16								16
17 Purchase New Air Compressor	2014	2,850						17
18 New Water Heater	2014	7,980						18
19 Parking Lot Resurfacing	2014	4,687						19
20 Replace Boiler	2014	16,814						20
21 Replace Condenser	2014	3,092						21
22 Wiring and Cabling for Point of Care Kiosks	2014	12,437						22
23								23
24 Circuit and wire installation for wall mounted heaters	2015	5,820						24
25 New air condensing unit - middle hallway	2015	4,628						25
26 New air handler (5 ton) - entry way	2015	5,387						26
27 Replace sewer line	2015	37,614						27
28 Radiator replacement	2015	3,624						28
29 Install 100 gallon water heater	2015	7,980						29
30 Replace sewer pipe and foundation wall	2015	6,580						30
31 Cabling - 30 Cat 6 to data room	2015	15,610						31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 5,006,903	\$ 265,146		\$ 265,146	\$	\$	34

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

Facility Name & ID Number Heritage Health Peru

0048090

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 12E, Carried Forward		\$ 5,006,903	\$ 265,146		\$ 265,146	\$	\$	1
2								2
3 Install hot water storage tank	2016	10,291						3
4 Replace fire alarm wiring	2016	3,984						4
5 Repair sewer and concrete walkway	2016	9,798						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								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)		\$ 5,030,976	\$ 265,146		\$ 265,146	\$	\$	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	\$1,658,150	\$77,606	\$77,606	\$		\$	71
72	Current Year Purchases	12,172						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,670,322	\$77,606	\$77,606	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,751,298	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$342,752	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$342,752	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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: \$18,126 Description:Televisions and office equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		\$	\$	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

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 377,345	\$		\$ 377,345	1
2	Licensed Speech and Language Development Therapist		hrs			60,237			60,237	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			407,393	154		407,547	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				764,639		764,639	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					59,806			59,806	13
14	TOTAL			\$		\$ 904,781	\$ 764,793		\$ 1,669,574	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	\$ 766	\$	1
2	Cash-Patient Deposits	23,885		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,451,200		3
4	Supply Inventory (priced at)	13,787		4
5	Short-Term Investments			5
6	Prepaid Insurance	36,298		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,964,612)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 561,324	\$	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)	\$ 561,324	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 196,031	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,885		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	410,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,712		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	33,901		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 667,842	\$	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)	\$ 667,842	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (106,518)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 561,324	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (147,920)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (147,920)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	41,402	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)	\$ 41,402	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)	\$ (106,518)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Peru

0048090

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	\$ 7,959,534	1
2	Discounts and Allowances for all Levels	(3,480,511)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,479,023	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,843,562	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,843,562	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	945	12
13	Barber and Beauty Care	2,046	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,479,488	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)	\$ 1,482,479	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,732	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,732	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)	\$ 8,806,796	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,133,813	31
32	Health Care	4,051,377	32
33	General Administration	2,088,947	33
	B. Capital Expense		
34	Ownership	644,996	34
	C. Ancillary Expense		
35	Special Cost Centers	846,261	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)*	\$ 8,765,394	40
41	Income before Income Taxes (line 30 minus line 40)**	41,402	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 41,402	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	1,758	1,850	\$ 71,952	\$ 38.89	1
2	Assistant Director of Nursing	1,809	1,904	60,460	31.75	2
3	Registered Nurses	26,143	27,519	854,141	31.04	3
4	Licensed Practical Nurses	14,191	14,938	393,154	26.32	4
5	CNAs & Orderlies	83,943	88,361	1,321,571	14.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,033	2,140	66,233	30.95	8
9	Activity Director					9
10	Activity Assistants	8,044	8,467	152,023	17.95	10
11	Social Service Workers	2,513	2,645	52,815	19.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,283	19,245	246,439	12.81	15
16	Dishwashers					16
17	Maintenance Workers	7,084	7,457	129,027	17.30	17
18	Housekeepers	4,763	5,014	60,495	12.07	18
19	Laundry	9,554	10,057	104,264	10.37	19
20	Administrator	1,984	2,088	89,847	43.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,818	12,440	349,462	28.09	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)	193,920	204,125	\$ 3,951,883 *	\$ 19.36	34

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		31,995		36
37	Medical Records Consultant		957		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,810		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,675		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,437		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 164		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 164		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Lori Walsh			\$ 89,847
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,847
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Heritage Operations Group	Mgt		\$ 372,270
ADP	Payroll Tax Processing		1,301
Tango	ACA Consulting		625
Benchmark Psychiatric	Consulting		299
Legal adj to Zero			13,374
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 387,869
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 89,599
Unemployment Compensation Insurance			39,382
FICA Taxes			302,319
Employee Health Insurance			213,227
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Other Benefits			41,064
Central Office Allocation			52,356
TOTAL (agree to Schedule V, line 22, col.8)			\$ 737,947
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			3,018
Health Care Worker Background Check (Indicate # of checks performed)			3,209
PR			12,871
Dues & Subscriptions			10,204
License & Fees			3,032
Central Office Allocation			12,679
Less: Public Relations Expense			(12,871)
Non-allowable advertising			(4,584)
Yellow page advertising (			)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 27,558
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
			5,534
			0
Seminar Expense			2,138
Central Office Allocation			(2,673)
Entertainment Expense (			)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 4,999

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>HCCI</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>7 Yrs</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>5,000</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>x</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>x</u> 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. This amount is to be recorded on line 42 of Schedule V.	\$ <u>246,485</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? (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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>Yes</u> Indicate the amount. \$ <u>133</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? 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? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>No</u> \$ <u>100%</u> <u>Yes</u> <u>Yes</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> \$ <u>0</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>Yes</u> <u>Sulaski & Webb</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees	<u>None Claimed</u>

Heritage Manor Peru
HFS ID# 203902978001
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	(69,975)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(176,510)
		<u>(246,485)</u>
		<u>(246,485)</u>
Provider Participation Fee	Line 42	<u>246,485</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(764,639)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(59,806)
		<u>(824,445)</u>
		<u>(824,445)</u>
Ancillary Service Centers	Line 39	<u>824,445</u>