FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0052357

Facility Name: Heddington Oaks

Address: 2223 W Heading Ave (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: (309) 636-3600 **Fax #** (309) 636-3610

HFS ID Number:

Date of Initial License for Current Owners: 09/25/2013

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/25/13 to 12/31/13 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) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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 9/25/13

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	20,972	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	214	TOTALS	214	20,972	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,605	4,418	1,750	16,773	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,605	4,418	1,750	16,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.98%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/25/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/25/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided 1,750

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	171,788	9,732		181,520		181,520		181,520			1
2	Food Purchase		108,056		108,056		108,056	(1,111)	106,945			2
3	Housekeeping	98,371	27,440		125,811		125,811		125,811			3
4	Laundry	55,005	5,783	3,793	64,581		64,581		64,581			4
5	Heat and Other Utilities			150,153	150,153		150,153		150,153			5
6	Maintenance	23,280	8,484	118,588	150,352		150,352	1,553	151,905			6
7	Other (specify):*											7
8	TOTAL General Services	348,444	159,495	272,534	780,473		780,473	442	780,915			8
	B. Health Care and Programs											
9	Medical Director			1,251	1,251		1,251		1,251			9
10	Nursing and Medical Records	1,308,550	165,902	223,614	1,698,066		1,698,066	(12,706)	1,685,360			10
10a	Therapy											10a
11	Activities	64,463	1,405	192	66,060		66,060		66,060			11
12	Social Services	39,875		192	40,067		40,067		40,067			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,412,888	167,307	225,249	1,805,444		1,805,444	(12,706)	1,792,738			16
	C. General Administration											
17	Administrative	34,398		56,520	90,918		90,918	(56,520)	34,398			17
18	Directors Fees							24,510	24,510			18
19	Professional Services			64,269	64,269		64,269	44,064	108,333			19
20	Dues, Fees, Subscriptions & Promotions			4,900	4,900		4,900	924	5,824			20
21	Clerical & General Office Expenses	115,897	1,933	9,813	127,643		127,643	144,545	272,188			21
22	Employee Benefits & Payroll Taxes			184,179	184,179		184,179	282,143	466,322			22
23	Inservice Training & Education			299	299		299		299			23
24	Travel and Seminar			970	970		970		970			24
25	Other Admin. Staff Transportation			1,651	1,651		1,651		1,651			25
26	Insurance-Prop.Liab.Malpractice			57,069	57,069		57,069	(51,134)	5,935			26
27	Other (specify):*											27
28	TOTAL General Administration	150,295	1,933	379,670	531,898		531,898	388,532	920,430			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,911,627	328,735	877,453	3,117,815		3,117,815	376,268	3,494,083			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heddington Oaks #0052357 **Report Period Beginning:** 9/25/13 **Ending:** 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			336,820	336,820		336,820	(1,271)	335,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,268,054	1,268,054		1,268,054	(3,015)	1,265,039			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,173	13,173		13,173		13,173			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,618,047	1,618,047		1,618,047	(4,286)	1,613,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,947	138,962	198,909		198,909		198,909			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,679	124,679		124,679		124,679			42
43	Other (specify):* Non-Allowable Cos			384,897	384,897		384,897	(384,897)				43
44	**TOTAL Special Cost Centers**		59,947	648,538	708,485		708,485	(384,897)	323,588			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,911,627	388,682	3,144,038	5,444,347		5,444,347	(12,915)	5,431,432			45

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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	(672)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,706)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,015)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,490)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	575	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(352,323)	43		24
25	Fund Raising, Advertising and Promotional	(23,280)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(11,934)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (404,845)		$	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)	391,930		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 391,930		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (12,915)		37

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

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

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

Heddington Oaks

ID# 0052357

Report Period Beginning: 9/25/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Revenue	$ (439)	2	1
2	Employee Recognitions & Awards	(550)	22	2
3	Disallow Medicare Ancillary Costs	(9,869)	43	3
4	Disallow Lobbying Costs	(2,000)	21	4
5	Background Checks	924	20	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
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,934)		49

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peoria County	100	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	County Admin Facility Mgmt	$	Peoria County	100.00%	$ 1,553	$ 1,553	1
2	V	17	Management Fee	56,520	Peoria County	100.00%		(56,520)	2
3	V	18	County Board		Peoria County	100.00%	24,510	24,510	3
4	V	19	Professional Services	36,250	Peoria County	100.00%	80,314	44,064	4
5	V	21	Clerical Services		Peoria County	100.00%	146,545	146,545	5
6	V	22	IMRF & FICA		Peoria County	100.00%	308,686	308,686	6
7	V	22	Employee Benefits - U/C	2,563	Peoria County	100.00%	1,721	(842)	7
8	V	22	Employee Benefits - Work Comp	48,571	Peoria County	100.00%	32,614	(15,957)	8
9	V	22	Health Insurance	183,629	Peoria County	100.00%	123,301	(60,328)	9
10	V	30	Equipment Depreciation		Peoria County	100.00%	219	219	10
11	V								11
12	V								12
13	V								13
14	Total			$ 327,533			$ 719,463	$ * 391,930	14

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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	Lynn Scott Pearson	Chairperson	Administrative	0.00	N/A	1	<1%	N/A	$ N/A	N/A	1
2	Robert Baietto	Vice-Chairperson	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	2
3	Mary Ardapple	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	3
4	Brian Elsasser	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	4
5	Brad Harding	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	5
6	Phillip Salzer	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	6
7	Sharon Williams	Member	Administrative	0.00	N/A	1	<1%	N/A	N/A	N/A	7
8											8
9	James Dillon, a member of the Peoria County Board, is the lead plumbing contractor from Dillon Plumbing.										9
10	Mr. Dillon is not a member of the Health, Environmental and Welfare Issues Committee Board, which directly oversees Heddington Oaks.										10
11	Andrew Rand, a member of the Peoria County Board, is CEO of Advanced Medical Transport (AMT). Bel-Wood uses AMT in the transportation of residents.										11
12	Mr. Rand is not a member of the Health, Environmental and Welfare Issues Committee Board, which directly oversees Heddington Oaks.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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 [X] NO [ ]

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

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

	1 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	6	Facility Management	Direct allocation per	1		$	$		$ 1,553	1
2	18	County Board	Maximus, Inc. Please	1					24,510	2
3	19	Professional Services	see attached schedule.	1					44,064	3
4	21	Clerical Services	Further detail	1					146,545	4
5	22	Employee Benefits-Health	available upon	1					(60,328)	5
6	22	Employee Benefits-Work Comp	request.	1					(15,957)	6
7	22	Employee Benefits-U/C		1					(842)	7
8	30	Equipment Depreciation		1					219	8
9										9
10	17	Management Fee	Direct Cost						(56,520)	10
11	22	IMRF	Direct Cost						178,081	11
12	22	FICA	Direct Cost						130,605	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	TOTALS					$	$		$ 391,930	25

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bond		X	New Facility	N/A	10/03/11	$ 42,000,000	$ 41,900,000	12/15/2041	0.0468	$ 1,268,054	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 42,000,000	$ 41,900,000			$ 1,268,054	9
	B. Non-Facility Related*											
10								Less: Interest Income Offset			(3,015)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,015)	14
15	TOTALS (line 9+line14)						$ 42,000,000	$ 41,900,000			$ 1,265,039	15

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

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

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)	2012	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011		11
2012	N/A	12

County facility-pays no real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heddington Oaks COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052357

CONTACT PERSON REGARDING THIS REPORT Joyce Harmon

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 147,086 B. General Construction Type: Exterior Masonry/Hardy Board Frame Steel Number of Stories Two

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	14.23 Acres	2011	$ 821,267	1
2					2
3	TOTALS			$ 821,267	3

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214			2013	$ 44,104,157	$ 275,651	40	$ 275,651	$	$ 275,651	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks (original)			2013	174,798	2,185	20	2,185		2,185	9
10	Curbs and gutters (original)			2013	101,904	1,274	20	1,274		1,274	10
11	Landscaping (original)			2013	202,800	2,535	20	2,535		2,535	11
12	Concrete paving (original)			2013	480,259	6,003	20	6,003		6,003	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											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 Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 45,063,918	$ 287,648		$ 287,648	$	$ 287,648	70

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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 ^	$ 66,332	$ 5,825	$ 5,825	$	5-15	$ 40,783	71
72	Current Year Purchases	1,509,738	40,499	40,499		5-10	40,499	72
73	Fully Depreciated Assets	56,700				5-15	56,700	73
74	Allocated from Peoria County			219	219			74
75	TOTALS	$ 1,632,769	$ 46,324	$ 46,543	$ 219		$ 137,982	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Maintenance	2000 Dodge Ram Truck^	2000	$ 13,998	$	$	$	8	$ 13,998	76
77	Resident Transportation	1997 Ford El Dorado^	1997	42,701				4	42,701	77
78	Facility Maintenance	2012 Ford F-250 4X2^	2012	27,165	1,358	1,358		5	7,697	78
79										79
80	TOTALS			$ 83,864	$ 1,358	$ 1,358	$		$ 64,396	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)	$ 47,601,818	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 335,330	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 335,549	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 219	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 490,026	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Facility Branding and Trademark	$ 59,595	$ 1,490	$ 1,490	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 59,595	$ 1,490	$ 1,490	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.**

^ Transferred from Bel-Wood Nursing Home 9/24/13

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ 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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 13,173 Description: Medical Equipment - $10,119; Duplicating Equipment - $3,054
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(2),(3)	hrs	$	832	$ 43,847	$ 4,222	832	$ 48,069	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		433	21,131		433	21,131	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,616	73,984		1,616	73,984	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				55,725		55,725	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	2,881	$ 138,962	$ 59,947	2,881	$ 198,909	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.

STATE OF ILLINOIS

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,624,651	$ 2,624,651	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 553,000)	4,003,149	4,003,149	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,002,311	5,002,311	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	101,814	101,814	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,731,925	$ 11,731,925	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	821,267	821,267	13
14	Buildings, at Historical Cost	44,104,157	44,104,157	14
15	Leasehold Improvements, at Historical Cost	959,761	959,761	15
16	Equipment, at Historical Cost	1,716,633	1,716,633	16
17	Accumulated Depreciation (book methods)	(491,516)	(490,026)	17
18	Deferred Charges	2,073	2,073	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): Intangible Assets	59,595	59,595	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,171,970	$ 47,173,460	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 58,903,895	$ 58,905,385	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 446,993	$ 446,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,071	202,071	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	79,253	79,253	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,528,614	2,528,614	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,256,931	$ 3,256,931	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	41,900,000	41,900,000	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)**	$ 41,900,000	$ 41,900,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 45,156,931	$ 45,156,931	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,746,964	$ 13,748,454	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 58,903,895	$ 58,905,385	48

*(See instructions.)

Heddington Oaks
0052357
9/25/13 - 12/31/13

Supplementary Information

Schedule 17A

XV. BALANCE SHEET - Line 36 - Other Current Liabilities

	Operating	After Consolidation
Accrued Vacation & Comp Time	295,039	295,039
Due to State of Illinois	123,660	123,660
Deferred Property Taxes	1,923,915	1,923,915
Deferred Revenue	186,000	186,000
Total P17 L 36	2,528,614	2,528,614
	-	-

Facility Name & ID Number Heddington Oaks **#** 0052357 **Report Period Beginning:** 9/25/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3	**Transfer from Bel-Wood**		15,661,730	3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	15,661,730	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(1,914,766)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	(1,914,766)	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)**	$	13,746,964	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,884,920	1
2	Discounts and Allowances for all Levels	(1,091,966)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,792,954	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	212,942	6
7	Oxygen	16,390	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 229,332	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		13
14	Non-Patient Meals	672	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	34,132	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)**	$ 34,804	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,015	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,015	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	469,476	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 469,476	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,529,581	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	780,473	31
32	Health Care	1,805,444	32
33	General Administration	531,898	33
	B. Capital Expense		
34	Ownership	1,618,047	34
	C. Ancillary Expense		
35	Special Cost Centers	583,806	35
36	Provider Participation Fee	124,679	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,444,347	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,914,766)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,914,766)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 862,458	44
45	Private Pay - Net Inpatient Revenue	1,419,008	45
46	Medicare - Net Inpatient Revenue	386,315	46
47	Other-(specify) Third Party	125,173	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,792,954	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

^ - Part of County. No return required.

Heddington Oaks
0052357
9/25/13 - 12/31/13

Supplementary Information

Schedule 19A

XVII. INCOME STATEMENT - Line 28a - Other Revenue

	Amount
Property Tax	468,950
Copies	27
Vending Machines	439
Recovery of Bad Debts	60
Total P19 L 28a	469,476
	-

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	512	560	$ 26,525	$ 47.37	1
2	Assistant Director of Nursing	1,060	1,120	36,744	32.81	2
3	Registered Nurses	4,143	4,591	121,230	26.41	3
4	Licensed Practical Nurses	17,102	18,847	422,350	22.41	4
5	CNAs & Orderlies	42,684	46,605	690,694	14.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	537	560	14,725	26.29	9
10	Activity Assistants	2,814	3,082	49,738	16.14	10
11	Social Service Workers	1,384	1,592	39,875	25.05	11
12	Dietician					12
13	Food Service Supervisor	552	560	18,014	32.17	13
14	Head Cook	555	571	15,722	27.53	14
15	Cook Helpers/Assistants	9,232	10,036	138,052	13.76	15
16	Dishwashers					16
17	Maintenance Workers	831	937	23,280	24.85	17
18	Housekeepers	6,754	7,612	98,371	12.92	18
19	Laundry	3,308	3,976	55,005	13.83	19
20	Administrator	492	560	34,398	61.43	20
21	Assistant Administrator					21
22	Other Administrative	1,069	1,178	24,100	20.46	22
23	Office Manager					23
24	Clerical	4,798	5,254	91,797	17.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	637	670	11,007	16.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,464	108,311	$ 1,911,627 *	$ 17.65	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	1,251	9(3)	36
37	Medical Records Consultant	Monthly	490	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	192	11(3)	44
45	Social Service Consultant	Monthly	192	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 2,125		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	708	$ 27,073	10(3)	50
51	Licensed Practical Nurses	3,760	115,393	10(3)	51
52	Certified Nurse Assistants/Aides	4,709	80,658	10(3)	52
53	TOTAL (lines 50 - 52)	9,177	$ 223,124		53

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matt Nieukirk	Administrator	0	$ 34,398
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 34,398

B. Administrative - Other

Description	Amount
Peoria County (Management Fee)	$ 56,520
Eliminated on P3, L17 C7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 56,520
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McGladrey LLP	Accounting	$ 2,800
Matt Koch	Accounting	622
Clifton Larson Allen	Accounting	15,367
Peoria County	Data Processing	36,250
E-Health Data Solutions	Data Management	8,730
US Bank	Financing	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 64,269

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,614
Unemployment Compensation Insurance	1,721
FICA Taxes	130,605
Employee Health Insurance	123,301
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	178,081
TOTAL (agree to Schedule V, line 22, col.8)	$ 466,322

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,279
Health Care Worker Background Check	
(Indicate # of checks performed 1)	9
Patient Background Checks 103	915
CMS Medicare Revalidation Fee	532
Miscellaneous Dues & Subscriptions	45
Miscellaneous Fees	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	320
Seminar Expense	650
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 970

* Attach copy of IMRF notifications

**See instructions.

Heddington Oaks
0052357
9/25/13 - 12/31/13

Schedule 21C

XIXI. Support Schedules - Section - Professional Services

	Amount
Per Schedule V, L19, C3	64,269
County Allocation	44,064
Per Schedule V, L19, C8	108,333

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3											N/A		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 9/25/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,101** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **124,679**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **672**

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

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Baker Tilly**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.