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: 0048157

Facility Name: Heritage Health Bloomington

Address: 700 East Walnut St (Number) Bloomington (City) 61701 (Zip Code)

County: McLean

Telephone Number: (309)827-8044 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			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) (Date)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid Preparer
(Signed) (Date)
(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 Bloomington # 0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/25/16

	1 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	111	Skilled (SNF)	88	34,140	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	111	TOTALS	88	34,140	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	7,893	12,381	3,759	24,033	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,893	12,381	3,759	24,033	14

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

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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 [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified and days of care provided 3,759

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: Fiscal Year:

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	253,365	16,159		269,524		269,524	4,603	274,127			1
2	Food Purchase		176,631		176,631		176,631		176,631			2
3	Housekeeping	109,426	31,039		140,465		140,465	33	140,498			3
4	Laundry	69,200	15,229		84,429		84,429		84,429			4
5	Heat and Other Utilities			104,323	104,323		104,323	1,430	105,753			5
6	Maintenance	101,543	37,436	109,357	248,336		248,336	19,261	267,597			6
7	Other (specify):*											7
8	**TOTAL General Services**	533,534	276,494	213,680	1,023,708		1,023,708	25,327	1,049,035			8
	B. Health Care and Programs											
9	Medical Director			15,828	15,828		15,828		15,828			9
10	Nursing and Medical Records	2,009,298	209,451	63,251	2,282,000		2,282,000	(21,272)	2,260,728			10
10a	Therapy		904,722	62,434	967,156	(966,884)	272		272			10a
11	Activities	62,813	2,647		65,460		65,460		65,460			11
12	Social Services	69,654		441	70,095		70,095		70,095			12
13	CNA Training							1,134	1,134			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,141,765	1,116,820	141,954	3,400,539	(966,884)	2,433,655	(20,138)	2,413,517			16
	C. General Administration											
17	Administrative	88,000			88,000		88,000		88,000			17
18	Directors Fees											18
19	Professional Services			324,244	324,244		324,244	(294,208)	30,036			19
20	Dues, Fees, Subscriptions & Promotions			229,925	229,925	(175,463)	54,462	(24,620)	29,842			20
21	Clerical & General Office Expenses	222,527	27,390	25,247	275,164		275,164	268,814	543,978			21
22	Employee Benefits & Payroll Taxes			537,871	537,871		537,871	36,278	574,149			22
23	Inservice Training & Education			13,961	13,961		13,961	1,112	15,073			23
24	Travel and Seminar			6,755	6,755		6,755	(1,756)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,651	62,651		62,651	15,219	77,870			26
27	Other (specify):* **Lost resident items**			(36,448)	(36,448)		(36,448)	36,469	21			27
28	**TOTAL General Administration**	310,527	27,390	1,164,206	1,502,123	(175,463)	1,326,660	37,308	1,363,968			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,985,826	1,420,704	1,519,840	5,926,370	(1,142,347)	4,784,023	42,497	4,826,520			29

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

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

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							588,784	588,784			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,086	40,086		40,086	136,539	176,625			32
33	Real Estate Taxes							88,973	88,973			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(484,070)	2,110			34
35	Rent-Equipment & Vehicles			17,658	17,658		17,658	8,193	25,851			35
36	Other (specify):*											36
37	**TOTAL Ownership**			543,924	543,924		543,924	338,419	882,343			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			803,125	803,125	966,884	1,770,009	(358,204)	1,411,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					175,463	175,463		175,463			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			803,125	803,125	1,142,347	1,945,472	(358,204)	1,587,268			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,985,826	1,420,704	2,866,889	7,273,419		7,273,419	22,712	7,296,131			45

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

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(3,326)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,363)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,499)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,542)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	36,469			24
25	Fund Raising, Advertising and Promotional	(33,406)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,667)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	37,379		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 37,379		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 22,712		37

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

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

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

Heritage Health Bloomington

ID# 0048157

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(5,542)	19	22
23				23
24		36,469	27	24
25		(33,406)	20	25
26				26
27		(3,326)	34	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,805)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,603	0	0	0	0	0	0	0	0	4,603	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	33	0	0	0	0	0	0	0	0	33	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,430	0	0	0	0	0	0	0	0	1,430	5
6	Maintenance	0	0	19,261	0	0	0	0	0	0	0	0	19,261	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	25,327	0	0	0	0	0	0	0	0	25,327	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(21,554)	282	0	0	0	0	0	0	0	0	(21,272)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,134	0	0	0	0	0	0	0	0	1,134	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(21,554)	1,416	0	0	0	0	0	0	0	0	(20,138)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,542)	(306,315)	17,649	0	0	0	0	0	0	0	0	(294,208)	19
20	Fees, Subscriptions & Promotions	(33,406)	0	8,786	0	0	0	0	0	0	0	0	(24,620)	20
21	Clerical & General Office Expenses	0	0	268,814	0	0	0	0	0	0	0	0	268,814	21
22	Employee Benefits & Payroll Taxes	0	0	36,278	0	0	0	0	0	0	0	0	36,278	22
23	Inservice Training & Education	0	0	1,112	0	0	0	0	0	0	0	0	1,112	23
24	Travel and Seminar	(7,499)	0	5,743	0	0	0	0	0	0	0	0	(1,756)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	15,219	0	0	0	0	0	0	0	0	15,219	26
27	Other (specify):*	36,469	0	0	0	0	0	0	0	0	0	0	36,469	27
28	**TOTAL General Administration**	(9,978)	(306,315)	353,601	0	0	0	0	0	0	0	0	37,308	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,978)	(327,869)	380,344	0	0	0	0	0	0	0	0	42,497	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	563,755	0	25,029	0	0	0	0	0	0	0	588,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,363)	137,633	0	269	0	0	0	0	0	0	0	136,539	32
33	Real Estate Taxes	0	88,973	0	0	0	0	0	0	0	0	0	88,973	33
34	Rent-Facility & Grounds	(3,326)	(486,180)	0	5,436	0	0	0	0	0	0	0	(484,070)	34
35	Rent-Equipment & Vehicles	0	0	0	8,193	0	0	0	0	0	0	0	8,193	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,689)	304,181	0	38,927	0	0	0	0	0	0	0	338,419	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(358,204)	0	0	0	0	0	0	0	0	0	(358,204)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(358,204)	0	0	0	0	0	0	0	0	0	(358,204)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,667)	(381,892)	380,344	38,927	0	0	0	0	0	0	0	22,712	45

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

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

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

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

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. [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)	
15	V	1	Dietary	$	Heritage Operations Group		$	$ 4,603	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					33	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,430	19
20	V	6	Maintenance					19,261	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					282	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,134	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					17,649	31
32	V	20	Fees, Subscription, Promotions					8,786	32
33	V	21	Clerical & General Office Expenses					268,814	33
34	V	22	Employee Benefits & Payroll Taxes					36,278	34
35	V	23	Inservice Training & Education					1,112	35
36	V	24	Travel and Seminar					5,743	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					15,219	38
39	Total			$			$ 0	$ * 380,344	39

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

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

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. [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)	
15	V	27	Other	$	Heritage Operations Group		$	$ 0	15
16	V	30	Depreciation					25,029	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					269	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,436	20
21	V	35	Rent-Equipment & Vehicles					8,193	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 38,927	39

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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 Bloomington # 0048157 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Heritage Operations Group
Street Address: Box 3188
City / State / Zip Code: Bloomington, IL 61701
Phone Number: ( )
Fax Number: ( )

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

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] 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 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	27	Other	Beds	2,571	26	$	$	88	$	1
2	30	Depreciation	Beds	2,571	26	731,247		88	25,029	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			88		3
4	32	Interest	Beds	2,571	26	7,851		88	269	4
5	33	Real Estate Taxes	Beds	2,571	26			88		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		88	5,436	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		88	8,193	7
8	36	Other	Beds	2,571	26			88		8
9	38	Medically Nec Transportation	Beds	2,571	26			88		9
10	39	Ancillary Service Centers	Beds	2,571	26			88		10
11	40	Barber and Beauty Shops	Beds	2,571	26			88		11
12	41	Coffee and Gift Shops	Beds	2,571	26			88		12
13	42	Other	Beds	2,571	26			88		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,137,301	$		$ 38,927	25

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		x	Mortgage			$	$			$ 130,215	1
2	Bank of America		x	Loan Fee Amortization							7,418	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							40,086	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 177,719	9
	B. Non-Facility Related*											
10	Interest Income										(1,363)	10
11												11
12	Allocated Corporate										269	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,094)	14
15	TOTALS (line 9+line14)						$	$			$ 176,625	15

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

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	88,973	2
3. Under or (over) accrual (line 2 minus line 1).	$	88,973	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	88,973	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	81,020	8
2012	81,153	9
2013	84,744	10
2014	86,147	11
2015	88,973	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		2104227012	$ 88,070.24	$ 88,070.24
2.		2104227010	$ 451.20	$ 451.20
3.		2104227009	$ 451.20	$ 451.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,972.64	$ 88,973.00

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 x NO

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,544 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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 [x] (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 [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				$ 255,078	1
2					2
3	TOTALS			$ 255,078	3

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,264,401	$ 162,436	$ 162,436	$		$	71
72	Current Year Purchases	28,651						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,293,052	$ 162,436	$ 162,436	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	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)	$ 11,656,825	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 588,784	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 588,784	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

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

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

G. Construction-in-Progress

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

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

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

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

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: *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,658 Description: Televisions and copiers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

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

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 ☐ 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 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		hrs	$		$ 334,812	$		$ 334,812	1
2	Licensed Speech and Language Development Therapist		hrs			96,815			96,815	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			371,498	272		371,770	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				904,450		904,450	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					62,434			62,434	13
14	TOTAL			$		$ 865,559	$ 904,722		$ 1,770,281	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 400	$	1
2	Cash-Patient Deposits	8,158		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,040,507		3
4	Supply Inventory (priced at)	12,753		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,453		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,390,192)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,297,921)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,297,921)	$	25

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

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,901,936)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,901,936)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,344	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 33,344	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,868,592)	24 *

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

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,508,064	1
2	Discounts and Allowances for all Levels	(3,840,002)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,668,062	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,865,501	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,865,501	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,899	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,326	16
17	Sale of Drugs	1,766,352	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	260	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,771,837	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,363	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,363	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,306,763	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,023,708	31
32	Health Care	3,400,539	32
33	General Administration	1,502,123	33
	B. Capital Expense		
34	Ownership	543,924	34
	C. Ancillary Expense		
35	Special Cost Centers	803,125	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,273,419	40
41	**Income before Income Taxes (line 30 minus line 40)****	33,344	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 33,344	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

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

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	1,668	1,756	$ 67,436	$ 38.40	1
2	Assistant Director of Nursing	1,505	1,584	49,059	30.97	2
3	Registered Nurses	15,304	16,109	518,171	32.17	3
4	Licensed Practical Nurses	16,658	17,536	455,186	25.96	4
5	CNAs & Orderlies	56,238	59,198	879,319	14.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,431	1,506	40,127	26.64	8
9	Activity Director					9
10	Activity Assistants	4,761	5,012	62,813	12.53	10
11	Social Service Workers	3,493	3,677	69,654	18.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,815	19,806	253,365	12.79	15
16	Dishwashers					16
17	Maintenance Workers	5,436	5,722	101,543	17.75	17
18	Housekeepers	8,579	9,031	109,426	12.12	18
19	Laundry	5,094	5,362	69,200	12.91	19
20	Administrator	1,984	2,088	88,000	42.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,887	7,249	222,527	30.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,853	155,636	$ 2,985,826 *	$ 19.18	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		15,828		36
37	Medical Records Consultant		37,840		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,262		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		441		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 58,371		49

C. CONTRACT NURSES

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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Holifield			$ 88,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,000

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 & Other	$ 306,340
ADP	Payroll Tax Processing	1,345
Tango Inc.	ACA Consultants	796
Lewis Yockey & Brown	Engineering Study	10,221
Legal adj to Zero		5,542
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 324,244

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,738
Unemployment Compensation Insurance	33,225
FICA Taxes	228,416
Employee Health Insurance	174,526
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	47,966
Central Office Allocation	36,278
TOTAL (agree to Schedule V, line 22, col.8)	$ 574,149

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	4,670
Health Care Worker Background Check	
(Indicate # of checks performed)	5,572
PR	17,060
Dues & Subscriptions	9,262
License & Fees	5,386
Central Office Allocation	8,786
Less: Public Relations Expense	(17,060)
Non-allowable advertising	(3,834)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,842

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	5,258
	55
Seminar Expense	1,442
	(1,756)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

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

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

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

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

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

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

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

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

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

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount					
1009			PETTY CASH	400							1,009	1,009	CASH	400
1010			CASH IN BANK								1,100	1,100	ACCTS RI	1,106,284
1040			CASH IN BANK-PAYROLL								1,101	1,101	ALLOW. I	(65,777)
1100			ACCOUNTS RECEIVABLE	1,040,507							1,110	1,110	ACCTS RECEIV-M/C	
1110			MEDICARE RECEIVABLES								1,125	1,125	ACCTS RECEIV-IPA	
1125			IPA INCOME RECEIVABLE								1,135	1,135	ACCTS RECEIV-IC	
1130			MEDICARE COST REPORT								1,140	1,140	UNAPPLIED CASH RECEIPTS	
1135			ACCOUNTS RECEIVABLE-IC								1,145	1,145	A/R SUSPENSE-REFUNDS	
1140			UNAPPLIED CASH RECEIPTS								1,200	1,200	PREPAID	30,453
1145			A/R SUSPENSE-REFUNDS								1,220	1,220	OTHER PREPAID EXPENSES	
1190			ACCRUED INTEREST REC								1,300	1,300	DIETARY INVENTORY	
1200			PREPAID INSURANCE	30,453							1,310	1,310	SUPPLIES	12,753
1220			OTHER PREPAID EXPENSES								1,320	1,320	LINEN INVENTORY	
1300			FOOD INVENTORY								1,409	1,409	LAND	0
1310			SUPPLIES INVENTORY	12,753							1,450	1,450	FURNITU	0
1409			LAND	0							1,460			0
1450			FURNITURE & EQUIPMENT	0							1,475	1,475	BUILDIN	0
1460			ACCUM DEPR-FURN & EQUI	0							1,490	1,490	ACCUM I	0
1475			BUILDING & IMPROVEMENT	0							1,530	1,530	RESIDEN	8,158
1490			ACCUM DEPR-BUILDING	0							1,550	1,550	LOAN FE	0
1530			RESIDENT FUNDS	8,158							1,551	1,551	LOAN FEES ADDED	
1550			LOAN FEES	0							1,850	1,850	INTERCO	(2,390,192)
1560			REAL ESTATE TAX ESCROW								2,010	2,010	ACCOUN	(258,431)
1575			REIMBURSABLE PURCHASES								2,100	2,095	BONUSES PAYABLE	
1850			INTRACOMPANY	-2,390,192							2,100	2,100	ACCRUEI	(119,526)
2010			ACCOUNTS PAYABLE	-258,431							2,100	2,100	PR CLEARING-BENEFITS	
2095			BONUSES PAYABLE								2,100	2,100	PR CLEARING-LABOR	
2100			ACCRUED PAYROLL	-119,526							2,110	2,110	ACCRUEI	(160,565)
2110			ACCRUED VACATION PAY	-160,565							2,120	2,120	U.C. TAX	0
2120			UC TAXES PAYABLE								2,125	2,125	FICA TAX	(3,511)
2125			FICA TAX PAYABLE	-3,511	-3,511						2,130	2,130	FEDERAL W/H TAX PAYABLE	
2130			FIT PAYABLE								2,140	2,140	STATE W/H TAX PAYABLE	
2140			STATE W/H PAYABLE		0						2,152	2,152	WORKERS COMP ACCRUAL	
2145			EARNED INCOME CREDIT								2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2150			UC FED CREDIT REDUCTION								2,230	2,230	PAYROLL SAVINGS	
2230			PAYROLL SAVINGS								2,235	2,240	UNITED FUND	
2235			IRA W/HOLDINGS								2,240	2,246	GROUP INSURANCE - CAFETERIA	
2240			UNITED WAY								2,246	2,250	401K W/H	
2245			GROUP INSURANCE PAYABLE								2,250			
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260	WAGE G/	0
2260			WAGE GARNISHMENTS								2,300	2,300	ACCRUEI	0
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320	IPA PAYM	(20,480)
2300			ACCRUED INTEREST PAYAI	0							2,350	2,350	REAL ESI	0
2310			SALES TAX PAYABLE								2,385			0
2320			IPA PAYMENTS PAYABLE	-20,480							2,400	2,400	CURRENT PORTION OF LT DEBT	
2350			REAL ESTATE TAX PAYABL	0							2,512	2,512	DUE TO F	(8,158)
2385			ACTIVITY FUND	0							2,600	2,600	LASALLE	0
2390			SECURITY DEPOSITS	0							2,600			
2391			VOLUNTEER FUND								2,625	2,625	LASALLE CONSTR. LOAN #2	
2393			HEART FUND/BAZAAR								2,625			
2395			DEFERRED INC EMP & MEM								2,695	2,695	CURRENT PORTION OF LT DEBT	
2400			CURRENT PORTION LT DEBT								2,720	2,720	RETAINE	1,901,936
2460			INCOME TAXES PAYABLE										net income	(33,344)
2512			DUE TO RESIDENTS	-8,158										
2600			MORTGAGE PAYABLE	0									balance	0
2650			EQUIPMENT LOAN PAYABLE											
2695			CURRENT PORTION LT DEBT											
2696			DEFERRED INCOME TAXES											
2710			COMMON STOCK											
2720			RETAINED EARNINGS	1,901,936										
2970			PROFIT/LOSS FOR PERIOD	-33,344										
3007.1			PATIENT DAYS-PRIVATE	12,381							3,007	3,007	PATIENT DA	12,381
3007.2			PATIENT DAYS-IPA	7,893							3,007	3,007	PATIENT DA	7,893
3007.3			PATIENT DAYS-MEDICARE	3,759							3,007	3,007	PATIENT DA	3,759
3007.4			PATIENT DAYS-CONVERSION								3,007			0
3007.5			PATIENT DAYS-LICENSED								3,007			
3007.6			PATIENT DAYS-TOTAL								3,007			
3010		1	BASIC CHARGE-PRIVATE &	-6,455,809		0	0	0	0		3,007			
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3,010	3,010	BASIC CHAR	(6,455,809)
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		3,020	3,020	BASIC CHAR	0
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		3,030	3,030	BASIC CHAR	0
3035		4	DAY CARE/HOME CARE			0	0	0	0		3,040			124,253
3040		1	LIGHT NURSING CARE			0	0	0	0		3,050			0
3050		1	MEDIUM NURSING CARE			0	0	0	0		3,060			0
3060		1	HEAVY NURSING CARE			0	0	0	0		3,061			0
3061		1	SKILLED NURSING CARE								3,080	3,080	NURSING SU	(27,786)
3080		1	NURSING SUPPLIES-PRIVAT	-27,786		0	0	0	0		3,081	3,081	NURSING SU	0
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3,082	3,082	NURSING SU	0
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3,083	3,083	NURSING SU	0
3083		1	NURSING SUPPLIES MED PT B								3,100	3,100	DRUGS-MED	(1,766,352)
3100		17	DRUGS	-1,766,352		0	0	0	0		3,101			0
3101		17	DRUGS-OTHER								3,110	3,110	PHYSICAL TI	(2,865,501)
3110		6	PT-PRIVATE	-2,865,501		0	0	0	0		3,111			0
3111		6	PT-IPA			0	0	0	0		3,112	3,112	PHYSICAL TI	0
3112		6	PT-MEDICARE PART A			0	0	0	0		3,113	3,113	PHYSICAL TI	0
3113		6	PT-MEDICARE PART B			0	0	0	0		3,140	3,140	LABORATORY INCOME	
3130		1	PUBLIC AID ASSESSMENT II	124,253							3,150			0
3140		19	LABORATORY INCOME			0	0	0	0		3,151			
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3,152	3,152	ST/OT THER/	0
3151		6	SPEECH/OT-IPA			0	0	0	0		3,153	3,153	ST/OT THER/	0
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3153		6	SPEECH/OT MED PART B								3,410	3,410	IPA/OTHER I	0
3410		2	IPA DISCOUNTS	3,840,002		0	0	0	0		3,411	3,411	MEDICARE F	0
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3,420	3,420	MEDICARE I	3,813,743
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3,500			
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3,520	3,520	RENT INCOM	(3,326)
3520		16	RENT INCOME	-3,326		6	0	6	-3,326		3,530	3,530	BEAUTY SH(	(1,899)
3530		13	BEAUTY SHOP	-1,899		0	0	0	0		3,560			0
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		3,570	3,570		
3570		12	VENDING INCOME/EXPENSI	0		0	0	0	0		3,590	3,590	EQUIPMENT	(24,469)
3580		12	MANAGEMENT FEES			0	0	0	0		3,595	3,595	RESIDENT TI	(260)
3590		1	EQUIPMENT RENTAL	-24,469		0	0	0	0		3,600	3,600	MISC INCOM	0
3595		21	RESIDENT TRANSPORTATIC	-260		0	0	0	0		4,110	4,110	G&A WAGES	202,600
3600		21	MISC INCOME	0		0	0	0	0		4,111	4,111	ADMINISTR/	88,000
4110			GENERAL & ADMINIST WA(	202,600	222,527	21	1	17	0		4,115	4,115	G&A PTO & I	19,927
4111			ADMINISTRATOR WAGES	88,000	88,000	17	1	0	0		4,120	4,120	EMPLOYEE I	26,873
4115			VACATION & SICK - G&A	19,927		21	1	0	0		4,121			
4120	4475		EMPLOYEE BENEFITS	28,305	537,871	22	3	0	0		4,130	4,130	EMPLOYEE S	14,965
4125			EMPLOYEE HEPETITIS VAC(	0		22	3	0	0		4,135	4,135	EMPLOYEE S	4,696
4130			EMPLOYEE SCHOLORSHIP V	14,965	124,253	21	1	0	0		4,250	4,250	OFFICE SUPI	14,131
4135			EMPLOYEE SCHOLORSHIP (	4,696		23	3	0	0		4,255	4,255	POSTAGE	2,586
4220			DIRECTORS FEES	0	0	18	3	0	0		4,260	4,260	TELEPHONE	25,247
4250	4255		OFFICE SUPPLIES	27,390	27,390	21	2	0	0		4,275	4,275	TRAINING &	13,961
4260			TELEPHONE	25,247	25,247	21	3	0	0		4,276			
4275			TRAINING & EMPLOYEE DE	13,961	13,961	23	3	16	0	**	4,280	4,280	GENERAL TI	5,258
4280			GENERAL TRAVEL	5,258	6,755	24	3	16	0		4,281	4,281	MEAL EXPEI	55
4281			MEAL EXPENSE FOR TRAVE	55		24	3	19	0		4,285	4,285	EDUCATION	1,303
4285			EDUCATION & SEMINAR	1,442		24	3	19	-7,499	***	4,289	4,289	MEETINGS E	139
4290			HELP WANTED ADVERTISIN	4,670	105,672	20	3	0	0	-51,210	4,290	4,290	HELP WANTI	4,670
4291			PROMOTIONAL ADVERTISII	12,512		20	3	25	-12,512		4,291	4,291	PROMOTION	12,512
4292			PUBLIC RELATIONS	17,060		20	3	25	-17,060		4,292	4,292	PUBLIC REL/	17,060
4300			LICENSES & FEES	56,596		20	3	17	0		4,300	4,300	LICENSE & F	56,596
4310			DUES & SUBSCRIPTIONS	9,262		20	3	17	-3,834		4,310	4,310	DUES & SUB	9,262
4320			CONTRIBUTIONS	0		27	3	20	0		4,320	4,320	CONTRIBUTI	0
4350			PROFESSIONAL FEES	17,929	324,244	19	3	22	-5,542		4,350	4,350	PROFESSION	17,929
4355			MEDICAL DIRECTOR	15,828	15,828	9	3	0	0		4,355	4,355	MEDICAL DI	15,828
4360			UTILIZATION REVIEW	0		10	3	0	0		4,362			37,840
4361			OTHER PHYSICIAN FEES			39	3	0	0		4,363			4,262
4362			MEDICAL RECORDS CONSU	37,840		10	3	0	0		4,364	4,364	SOCIAL SER'	441
4363			PHARMACIST FEES	4,262		10	3	0	0		4,370	4,370	TV RENTAL	10,807
4364			SOC SERV/ACT CONSULT	441	441	12	3	0	0		4,383	4,383	BACKGROUI	5,572
4370			TV RENTAL	10,807		35	3	5	0		4,390	4,390	OTHER TAXI	0
4380			INCOME TAXES		-36,448	27	3	26	0		4,400	4,400	PAYROLL T/	252,507
4383			BACKGROUND CHECKS	5,572		20	3	26	0		4,401	4,401	PAYROLL T/	9,134
4400			PAYROLL TAXES	252,507		22	3	0	0		4,410	4,410	GROUP INSU	174,526
4401			PAYROLL TAXES ADMINISI	9,134		22	3	0	0		4,420	4,420	LIABILITY II	62,651
4410			GROUP INSURANCE	174,526		22	3	0	0		4,430	4,430	WORKMAN'S	52,797
4420			LIABILITY INSURANCE	62,651	62,651	26	3	0	0		4,435	4,435	W/C-FIRST A	0
4425			INSURANCE-OWNERS			22	3	21	0		4,436	4,436	DRUG TESTI	941
4430			WORKMENS COMP INSURAI	53,738		22	3	0	0		4,450	4,450	MANAGEME	306,315
4450			CENTRAL OFFICE FEES	306,315		19	3	34	0	**	4,460	4,460	BAD DEBTS	(36,469)
4460			BAD DEBTS	-36,469		27	3	24	36,469		4,461	4,461	BAD DEBTS	26,259
4470			LOST ITEMS-RESIDENTS	21		27	3	0			4,470	4,470	LOST ITEMS-	21
4490			MISCELLANEOUS	0		27	3	0	0		4,475	4,475	UNIFORM E)	1,432
4510			REAL ESTATE TAXES	0	0	33	3	0	0		4,486	4,486	M.I.S. Softwar	40,124
4600			LEASED EQUIPMENT	6,851	17,658	35	3	16	0		4,490	4,490	MISC EXPEN	370
5110			MAINTENANCE SALARIES	92,681	101,543	6	1	0	0		4,496	4,496	MISC. M.I.S. I	10,673
5120			MAINTENANCE SICK & VAC	8,862		6	1	0	0		4,510	4,510	REAL ESTAT	0
5130			ELECTRIC	57,482	104,323	5	3	0	0		4,600	4,600	LEASED EQU	6,851
5131			NATURAL GAS	21,163		5	3	0	0		5,110	5,110	MAINTENAN	92,681
5132			HEATING & DEISEL OIL			5	3	0	0		5,120	5,120	MAINTENAN	8,862
5133			WATER & SEWER	25,678		5	3	0	0		5,130	5,130	ELECTRIC	57,482
5134			TRASH COLLECTION	10,477	109,357	6	3	0	0		5,131	5,131	NATURAL G.	21,163
5140			PROPERTY PLANT REPLACE	9,108	37,436	6	2	0	0		5,133	5,133	WATER & SE	25,678
5160			GENERAL REPAIR & MAINT	28,328		6	2	0	0		5,134	5,134	TRASH COLI	10,477
5165			MAINTENANCE CONTRACT	98,880		6	3	0	0		5,140	5,140	PROP/PLANT	9,108
5210			DIETARY WAGES	230,469	253,365	1	1	0	0		5,160	5,160	GENERAL RI	28,328
5220			DIETARY SICK & VAC	22,896		1	1	0	0		5,165	5,165	MAINTENAN	58,756
5240			SALES TAX			2	3	13	0		5,210	5,210	DIETARY W/	230,469
5248			FOOD PURCHASES	182,531	176,631	2	2	0	0		5,220	5,220	DIETARY PT	22,896
5250			SUPPLIES-DISHWASHING	2,650	16,159	1	2	0	0		5,248	5,248	FOOD PURCI	182,161
5260			DIETARY REPLACEMENT	6,046		1	2	0	0		5,250	5,250	SUPPLIES DI	2,650
5270			KITCHEN SUPPLIES-PAPER	7,463		1	2	0	0		5,260	5,260	REPLACEME	6,046
5295			MEAL CREDIT	-5,900		2	2	0	0		5,270	5,270	KITCHEN SU	7,463
5310			LAUNDRY WAGES	63,564	69,200	4	1	0	0		5,295	5,295	MEAL INCOI	(5,900)
5340			LAUNDRY SICK & VAC	5,636		4	1	0	0		5,310	5,310	LAUNDRY W	63,564
5370			LAUNDRY REPLACEMENT	10,700	15,229	4	2	0	0		5,340	5,340	LAUNDRY P	5,636
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		5,370	5,370	REPLACEME	10,700
5390			LAUNDRY SUPPLIES	4,529		4	2	0	0		5,380			0
5410			HOUSEKEEPING WAGES	102,007	109,426	3	1	0	0		5,390	5,390	SUPPLIES	4,529
5440			HOUSEKEEPING SICK & VA(	7,419		3	1	0	0		5,410	5,410	HOUSEKEEP	102,007
5480			HOUSEKEEPING SUPPLIES	31,039	31,039	3	2	0	0		5,440	5,440	HOUSEKEEP	7,419
5490			HOUSEKEEPING SUPPLIES-I	0		3	2	0	0		5,480	5,480	SUPPLIES-CI	31,039
6010			RN WAGES-MEDICARE		2,009,298	10	1	0	0		5,490	5,490	SUPPLIES-H(	0
6020			RN WAGES-NON MEDICARE	467,965		10	1	0	0		6,020	6,020	RN WAGES	467,965
6030			DON WAGES	67,436		10	1	0	0		6,030	6,030	DON WAGES	67,436
6035			ADON	49,059		10	1	0	0		6,035	6,035	ADON WAGI	49,059
6040			RN SICK & VACATION	50,206		10	1	0	0		6,040	6,040	RN PTO & RI	50,206
6110			LPN WAGES-MEDICARE	415,076		10	1	0	0		6,120	6,120	LPN WAGES	415,076
6120			LPN WAGES-NON MEDICAR	0		10	1	0	0		6,140	6,140	LPN PTO & R	40,110
6130			LPN WAGES OTHER			10	1	0	0		6,220	6,220	AIDES WAGI	833,338
6140			LPN SICK & VACATION	40,110		10	1	0	0		6,240	6,240	AIDES PTO &	45,981
6210			AIDE WAGES-MEDICARE			10	1	0	0		6,245			16,230
6220			AIDE WAGES-NON MEDICAI	833,338		10	1	0	0		6,246			
6230			WARD CLERKS			10	1	0	0		6,247			
6240			AIDE VACATION & SICK	45,981		10	1	0	0		6,250			0
6245			CONTRACT NURSES-RN	16,230		10	3	0	0		6,255			0
6246			CONTRACT NURSES-LPN	0		10	3	0	0		6,260			0
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		6,270	6,270	REHAB WAG	36,256
6250			NURSE AIDE TRAINING WA(	0	0	13	1	0	0		6,275	6,275	REHAB PTO	3,871
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0		6,290	6,290	NURSING SU	191,738
6260			NURSE AIDE TRAINING REII	0		0	0	0	0		6,295	6,295	NURSING SU	14,940
6270			REHAB WAGES	36,256		10	1	0	0		6,390	6,390	REPLACEME	2,773
6275			REHAB SICK & VAC	3,871		10	1	0	0		6,490	6,490	OTHER	4,919
6280			NURSING DEPT EDUCATION			23	3	0	0		7,280	7,280	DRUG PURCI	554,429
6290			NURSING SUPPLIES	191,738	209,451	10	2	0	0		7,281	7,281	DRUG PURCI	350,021
6295			NURSING SUPPLIES	14,940		10	2	0	0		7,380	7,380	LABORATOF	0
6390			REPLACEMENT-NURSING	2,773		10	2	0	0		7,391	7,390	X-RAY SERV	62,434
6490			NURSING OTHER	4,919	63,251	10	3	0	0		7,393			
7280			DRUG PURCHASES	554,429	904,722	39	2	0	0	***	7,510	7,510	ACTIVITIES '	58,792
7281			DRUG PURCHASES-OTHER	350,021		39	2				7,540	7,540	ACTIVITIES I	4,021
7380			LABORATORY SERVICES	62,434	62,434	39	3	0	0		7,590	7,590	ACTIVITIES :	2,647
7410			HOME HEALTH SALARY			39	1	0	0		7,620	7,620	PHYSICAL TI	371,498
7440			HOME HEALTH SICK & VAC			39	1	0	0		7,660	7,660	P.T. SUPPLY	272
7450			HOME HEALTH EXPENSES			39	3	0	0		7,710	7,710	SOCIAL SER'	64,056
7510			ACTIVITES WAGES	58,792	62,813	11	1	0	0		7,720	7,720	SOCIAL SER'	5,598
7540			ACTIVITIES SICK & VAC	4,021		11	1	0	0		7,730	7,730	SOCIAL SERVICE-EXPENSES	
7590			ACTIVITIES SUPPLIES	2,647	2,647	11	2	0	0		7,740	7,740	OCCUPATIO	334,812
7595			ACTIVITIES FEES	0	0	11	3	0	0		7,750			0
7610			PT WAGES			39	1	0	0		7,770	7,770	SPEECH THE	96,815
7611			PT SICK & VACATION			39	1	0	0		7,820	7,820	BEAUTICIAN	0
7620			PT FEES	371,498	803,125	39	3	0	0	***	7,890			0
7660			PT SUPPLIES	272		39	2	0	0		7,960			0
7710			SOCIAL SERVICE WAGES	64,056	69,654	12	1	0	0		8,120	8,120	INTEREST	0
7720			SOCIAL SERVICE SICK & VA	5,598		12	1	0	0		8,125			40,086
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		8,130	8,130	DEPRECIATI	0
7740			OT FEE	334,812		39	3	0	0	***	8,150			0
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510	9,510	INTEREST IN	(1,363)
7770			SPEECH THERAPY FEE	96,815		39	3	0	0	***	9,520	9,520	MISC NON-O	0
7800			BEAUTICIAN WAGES		0	40	1	0	0		9,530	4,220		0
7810			BEAUTICIAN SICK & VAC			40	1	0	0			8,100		486,180
7820			BEAUTICIAN FEES	0	0	40	3	0	0			9,702		0
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0			5,230		0
7910			VOLUNTEER COORDINATOR			21	1	0	0					(33,344)
7940			VOL COORD SICK & VAC			21	1	0	0					
7960			VOL COORD SUPPLIES	0		21	2	0	0					
8100			RENT	486,180	486,180	34	3	0	0				Expenses Fixed Assets	
8120			INTEREST EXPENSE	40,086	40,086	32	3	14	-1,363					0
8130			DEPRECIATION	0	0	30	3	9	0					
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0				
9510			INTEREST INCOME	-1,363		32	0	10	0					
9520			MISC NON-OPERATING INC(	0		0	0	0	0					
9700			INCOME TAXES	0		0	0	0	0					
				7,147,803	7,273,419									
					125,616									
GRAND TOTALS				-33,344					-14,667					
				(NET INCOME)										
				0										

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	12,381	12,381
IPA	7,893	7,893
medicare	3,759	3,759
		24,033

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

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