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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0052357

Facility Name: Heddington Oaks

Address: 2223 West Heading Avenue (Number) West 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: 11/30/1968

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 1/1/2017 to 12/31/2017 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) RSM US 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: 1/1/2017 Ending: 12/31/2017

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 N/A

	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	78,110	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	78,110	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	32,784	18,697	4,349	55,830	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,784	18,697	4,349	55,830	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.48%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 [ ] Date New Construction 2013 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 45 and days of care provided 3,034

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: ######## Fiscal Year: 12/31/2017

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	685,986	23,018	-	709,004		709,004	-	709,004			1
2	Food Purchase		364,456		364,456		364,456	(7,499)	356,957			2
3	Housekeeping	321,842	41,203	-	363,045		363,045	-	363,045			3
4	Laundry	84,104	22,278	-	106,382	-	106,382	-	106,382			4
5	Heat and Other Utilities			343,603	343,603		343,603	-	343,603			5
6	Maintenance	89,809	25,575	238,725	354,109		354,109	-	354,109			6
7	Other (specify):*	-	-	-	-		-	-	-			7
8	**TOTAL General Services**	1,181,741	476,530	582,328	2,240,599	-	2,240,599	(7,499)	2,233,100			8
	B. Health Care and Programs											
9	Medical Director	-	-	5,004	5,004		5,004	-	5,004			9
10	Nursing and Medical Records	4,427,488	426,710	1,072,140	5,926,338		5,926,338	(48,368)	5,877,970			10
10a	Therapy	-	-	-	-		-	-	-			10a
11	Activities	288,537	6,109	680	295,326		295,326	-	295,326			11
12	Social Services	167,661	-	646	168,307		168,307	-	168,307			12
13	CNA Training	-	-	-	-		-	-	-			13
14	Program Transportation	-	-	-	-		-	-	-			14
15	Other (specify):*	-	-	-	-		-	-	-			15
16	**TOTAL Health Care and Programs**	4,883,686	432,819	1,078,470	6,394,975	-	6,394,975	(48,368)	6,346,607			16
	C. General Administration											
17	Administrative	91,569	-	81,960	173,529		173,529	(59,098)	114,431			17
18	Directors Fees			-	-		-	-	-			18
19	Professional Services			630,282	630,282		630,282	201,131	831,413			19
20	Dues, Fees, Subscriptions & Promotions			22,627	22,627		22,627	(2,414)	20,213			20
21	Clerical & General Office Expenses	418,683	11,605	28,073	458,361		458,361	69,547	527,908			21
22	Employee Benefits & Payroll Taxes			909,501	909,501		909,501	670,845	1,580,346			22
23	Inservice Training & Education			17,818	17,818		17,818	(3,348)	14,470			23
24	Travel and Seminar			1,745	1,745		1,745	-	1,745			24
25	Other Admin. Staff Transportation		-	-	-		-	-	-			25
26	Insurance-Prop.Liab.Malpractice			235,920	235,920		235,920	(211,381)	24,539			26
27	Other (specify):*	-	-	-	-		-	-	-			27
28	**TOTAL General Administration**	510,252	11,605	1,927,926	2,449,783	-	2,449,783	665,282	3,115,065			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,575,679	920,954	3,588,724	11,085,357	-	11,085,357	609,415	11,694,772			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: 1/1/2017 Ending: 12/31/2017

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			1,388,529	1,388,529		1,388,529	10,655	1,399,184			30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-			31
32	Interest			1,942,507	1,942,507		1,942,507	(40,560)	1,901,947			32
33	Real Estate Taxes			-	-		-	-	-			33
34	Rent-Facility & Grounds			-	-		-	-	-			34
35	Rent-Equipment & Vehicles			29,295	29,295		29,295	-	29,295			35
36	Other (specify):*			-	-		-	-	-			36
37	**TOTAL Ownership**			3,360,331	3,360,331	-	3,360,331	(29,905)	3,330,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-		-	-	-			38
39	Ancillary Service Centers	-	305,289	551,824	857,113		857,113	-	857,113			39
40	Barber and Beauty Shops	-	-	-	-		-	-	-			40
41	Coffee and Gift Shops	-	-	-	-		-	-	-			41
42	Provider Participation Fee			434,129	434,129		434,129	-	434,129			42
43	Other (specify):* Non-Allowable Cos	-	-	1,560,173	1,560,173		1,560,173	(1,560,173)	-			43
44	**TOTAL Special Cost Centers**	-	305,289	2,546,126	2,851,415	-	2,851,415	(1,560,173)	1,291,242			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,575,679	1,226,243	9,495,181	17,297,103	-	17,297,103	(980,663)	16,316,440			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: 1/1/2017 Ending: 12/31/2017

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	(7,499)	2		4
5	Telephone, TV & Radio in Resident Rooms	(48,368)	10		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,959)	30		9
10	Interest and Other Investment Income	(40,560)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,355)	43		18
19	Entertainment	(265)	43		19
20	Contributions	10,823	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,395,976)	43		24
25	Fund Raising, Advertising and Promotional	(83,497)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(77,337)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,664,993)		$	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)	684,330		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 684,330		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (980,663)		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: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Medicare Ancillary Costs	$ (74,903)	43	1
2	Lobbying Cost	(2,414)	20	2
3	Miscellaneous Income	(20)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(77,337)		49

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	17	Management Fee	$ 81,960	Peoria County	100.00%	$	$ (81,960)	1
2	V	18	County Board & Administration		Peoria County	100.00%	22,862	22,862	2
3	V	19	County Auditor		Peoria County	100.00%	10,325	10,325	3
4	V	19	Finance		Peoria County	100.00%	230,311	230,311	4
5	V	19	Information Technology	588,000	Peoria County	100.00%	490,741	(97,259)	5
6	V	19	State's Attorney		Peoria County	100.00%	57,754	57,754	6
7	V	21	Human Resources		Peoria County	100.00%	69,567	69,567	7
8	V	22	Retirement & Employer Taxes		Peoria County	100.00%	1,334,442	1,334,442	8
9	V	22	Unemployment	10,593	Peoria County	100.00%	2,648	(7,945)	9
10	V	22	Work Comp	200,788	Peoria County	100.00%	50,183	(150,605)	10
11	V	22	Health Insurance	909,501	Peoria County	100.00%	189,725	(719,776)	11
12	V	30	Depreciation - Equip & Vehicle		Peoria County	100.00%	16,614	16,614	12
13	V								13
14	Total			$ 1,790,842			$ 2,475,172	$ * 684,330	14

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Andrew A. Rand	Chairman						1
2	Stephen Morris	Vice-Chairper						2
3	Gregory J. Adamson	Member						3
4	Brad Harding	Member						4
5	Robert E. Baietto	Member						5
6	Allen Mayer	Member						6
7	James C. Dillon	Member						7
8	Brian Elsasser	Member						8
9	Thomas H. O'Neill, III	Member						9
10	James T. Fennell	Member						10
11	Rachel Parker	Member						11
12	Kate Pastucha	Member						12
13	Paul Rosenbohm	Member						13
14	Phillip Salzer	Member						14
15	Steven Rieker	Member						15
16	William Watkins, Jr.	Member						16
17	Barry John Robinson	Member						17
18	Sharon K. Williams	Member						18
19		Member						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Refer to Page 6-Supplemental								$		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 Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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	18	County Board & Administration	Direct allocation per	1		$	$		$ 22,862	1
2	19	County Auditor	Maximus, Inc. Please	1					10,325	2
3	19	Finance	see attached schedule.	1					230,311	3
4	19	Information Technology	Further detail	1					490,741	4
5	19	State's Attorney	available upon	1					57,754	5
6	21	Human Resources	request.	1					69,567	6
7	22	Employee Benefits - U/C		1					2,648	7
8	22	Employee Benefits-Work Comp		1					50,183	8
9	22	Employee Benefits - Health		1					189,725	9
10	30	Depreciation - Equip & Vehicle		1					16,614	10
11										11
12										12
13	22	IMRF	Direct Cost						805,316	13
14	22	FICA	Direct Cost						529,126	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,475,172	25

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 41,500,000	12/15/2041	0.0468	$ 1,889,950	1
2	Bond Premium		X	New Facility	N/A	10/03/11	585,168	520,149	12/15/2041	0.0468	(21,673)	2
3												3
4												4
5												5
	Working Capital											
6	Peoria County	X		New Facility	$33,976.68	6/30/2014	3,500,000	2,223,605	12/30/2023	0.0300	74,230	6
7												7
8												8
9	TOTAL Facility Related				$33,976.68		$ 46,085,168	$ 44,243,754			$ 1,942,507	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(40,560)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (40,560)	14
15	TOTALS (line 9+line14)						$ 46,085,168	$ 44,243,754			$ 1,901,947	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: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	2016	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 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.)	Alloc Fr. Mgmt Co.	$	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:			
	2012	N/A	8
	2013		9
	2014		10
	2015		11
	2016		12

County facility-pays no real estate tax.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heddington Oaks COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052357

CONTACT PERSON REGARDING THIS REPORT Randy Brunner

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 N/A NO

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	$ 1,102,604	40	$ 1,102,604	$	$ 4,686,067	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Sidewalks (original)			2013	174,797	8,741	20	8,741		37,146	9
10	Curbs and gutters (original)			2013	101,904	5,095	20	5,095		21,655	10
11	Landscaping (original)			2013	202,800	10,140	20	10,140		43,095	11
12	Concrete paving (original)			2013	480,259	24,013	20	24,013		102,055	12
13											13
14	Laundry Room Structural Improvements			2014	5,600	560	10	560		1,773	14
15	ERV Unit Rework - Mechanical Room			2014	16,000	1,600	10	1,600		5,067	15
16											16
17	Storage Building			2015	155,820	7,792	20	7,792		22,075	17
18	Hill Erosion Repair			2015	19,770	1,977	10	1,977		4,778	18
19											19
20	Muffin Monster Grinder - Located in manhole near SE corner of the facil			2016	93,269	9,327	10	9,327		16,322	20
21	Wall Protection (Rooms B110, B111, B112)			2016	16,544	1,654	10	1,654		1,654	21
22	Security camera drive repairs-server room basement			2017	5,768	577	5	577		577	22
23	Patient bed receptacles (electrical) B-1102,113,114,115,116,126			2017	4,600	268	10	268		268	23
24	B2-202,213,2114,215,216,226										24
25	C1-102,113,114,115,116,127										25
26	D1-102,113,114,115,116,127										26
27	D2-202,213,214,215,216,227										27
28											28
29	RTU #1 Repairs-Northwest Section of roof			2017	3,216	214	5	214		214	29
30	RTU #1 Repairs-Northwest Section of roof			2017	3,335	167	5	167		167	30
31	Condensor Coil RTU #3-Center west section of roof			2017	5,815	97	5	97		97	31
32	Smoke Detector (Closets)-common area one eachside B1,B2 and D2			2017	3,698		5				32
33	South Kitchen Door Repl			2017	3,370	169	5	169		169	33
34	RTU #4 Repair is on Center East section roof			2017	2,712	271	5	271		271	34
35	Non-Care asset					5,959			(5,959)		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: 1/1/2017 Ending: 12/31/2017

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)		$ 45,403,435	$ 1,181,225		$ 1,175,266	$ (5,959)	$ 4,943,449	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: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,588,264	$ 175,727	$ 175,727	$	5-15	$ 724,749	71
72	Current Year Purchases	105,461	16,004	16,004		3-5	16,004	72
73	Fully Depreciated Assets	118,391	1,346	1,346		5-15	118,391	73
74				16,614	16,614			74
75	TOTALS	$ 1,812,116	$ 193,077	$ 209,691	$ 16,614		$ 859,144	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Maintenance	2012 Ford F-250 4X2	2012	$ 27,165	$ 3,169	$ 3,169	$	5	$ 27,165	76
77	Resident Transporation	2014 Ford Transport Bus	2014	55,290	11,058	11,058		5	43,310	77
78					-	-				78
79					-	-				79
80	TOTALS			$ 82,455	$ 14,227	$ 14,227	$		$ 70,475	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)	$ 48,119,273	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,388,529	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,399,184	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,655	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,873,068	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Facility Branding and Trademark	$ 59,595	$ 5,959	$ 25,328	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 59,595	$ 5,959	$ 25,328	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.

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 29,295 Description: Medical Equipment - $19,297; Duplicating Equipment - $9,998
(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: 1/1/2017 Ending: 12/31/2017

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

STATE OF ILLINOIS
0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$	4,476	$ 250,119	$ 680	4,476	$ 250,799	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		370	49,963		370	49,963	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,782	251,742		4,782	251,742	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				248,203		248,203	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					56,406		56,406	12
13	Other (specify):									13
14	TOTAL			$	9,628	$ 551,824	$ 305,289	9,628	$ 857,113	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:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 97,647	$ 97,647	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (3,990,000))	4,802,844	4,802,844	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,127,012	5,127,012	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	101,386	101,386	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intangible Assets	59,595	59,595	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,188,484	$ 10,188,484	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	44,259,977	44,259,977	14
15	Leasehold Improvements, at Historical Cost	1,143,458	1,143,458	15
16	Equipment, at Historical Cost	1,894,571	1,894,571	16
17	Accumulated Depreciation (book methods)	(5,898,396)	(5,873,068)	17
18	Deferred Charges	2,331	2,331	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)**	$ 42,223,208	$ 42,248,536	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 52,411,692	$ 52,437,020	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,366,835	$ 2,366,835	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,606	242,606	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	82,949	82,949	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	678,961	678,961	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,371,351	$ 3,371,351	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,223,605	2,223,605	39
40	Mortgage Payable			40
41	Bonds Payable	42,020,149	42,020,149	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 44,243,754	$ 44,243,754	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 47,615,105	$ 47,615,105	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,796,587	$ 4,821,915	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 52,411,692	$ 52,437,020	48

***(See instructions.)**

Facility Name: **Tabor Hills Health Care Facility, Inc.**
IDPH License ID Number: **0040543**
Fiscal Year End: **1/0/1900**

Schedule 17A

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

Description	Operating	After Consolidation
DIP Provider Payable	37,500	37,500
Accrued Vac/Comp Time	238,432	238,432
State of Illinois	122,979	122,979
Deferred Revenue	280,050	280,050
Total - Line 36	**678,961**	**678,961**

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,635,811	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,635,811	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,839,224)	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)**	$ (2,839,224)	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)**	$ 4,796,587	24 *

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

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 13,380,944	1
2	Discounts and Allowances for all Levels	(2,305,540)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,075,404	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,047,359	6
7	Oxygen	49,521	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,096,880	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	7,499	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	186,381	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)**	$ 193,880	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40,560	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40,560	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	2,051,155	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,051,155	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,457,879	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,240,599	31
32	Health Care	6,394,975	32
33	General Administration	2,449,783	33
	B. Capital Expense		
34	Ownership	3,360,331	34
	C. Ancillary Expense		
35	Special Cost Centers	2,417,286	35
36	Provider Participation Fee	434,129	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,297,103	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,839,224)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,839,224)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,956,192	44
45	Private Pay - Net Inpatient Revenue	3,515,116	45
46	Medicare - Net Inpatient Revenue	1,049,205	46
47	Other-(specify) Third Party	554,891	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,075,404	49

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

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

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

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

^-County home. No tax return required.

Facility Name: **Tabor Hills Health Care Facility, Inc.**
IDPH License ID Number: **0040543**
Fiscal Year End: **1/0/1900**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Restitution	977
Property Tax	2,049,874
Copies	44
Miscellaneous (Unanticipation)	20
Recovery of Bad Debt	240
Total - Line 28	**2,051,155**

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	1,808	2,081	$ 76,539	$ 36.78	1
2	Assistant Director of Nursing	1,521	1,658	51,185	30.87	2
3	Registered Nurses	20,127	23,618	685,782	29.04	3
4	Licensed Practical Nurses	42,015	49,365	1,158,583	23.47	4
5	CNAs & Orderlies	149,791	167,676	2,415,363	14.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,778	2,082	55,569	26.69	9
10	Activity Assistants	12,085	14,226	232,968	16.38	10
11	Social Service Workers	5,486	6,579	167,661	25.48	11
12	Dietician					12
13	Food Service Supervisor	1,800	2,066	69,019	33.41	13
14	Head Cook	1,885	2,344	54,325	23.18	14
15	Cook Helpers/Assistants	36,566	45,460	562,642	12.38	15
16	Dishwashers					16
17	Maintenance Workers	2,825	3,744	89,809	23.99	17
18	Housekeepers	21,939	25,250	321,842	12.75	18
19	Laundry	7,895	8,918	84,104	9.43	19
20	Administrator	1,871	2,081	91,569	44.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,362	23,530	418,683	17.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,873	2,308	40,036	17.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	333,627	382,986	$ 6,575,679 *	$ 17.17	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	5,004	9(3)	36
37	Medical Records Consultant	Monthly	2,080	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	680	11(3)	44
45	Social Service Consultant	Monthly	646	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 8,410		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,439	$ 100,085	10(3)	50
51	Licensed Practical Nurses	8,764	422,688	10(3)	51
52	Certified Nurse Assistants/Aides	28,470	547,287	10(3)	52
53	TOTAL (lines 50 - 52)	39,673	$ 1,070,060		53

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Timothy Turpin	Executive Director	0	$ 91,569
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,569

B. Administrative - Other

Description	Amount
Peoria County (Management Fees)	$ 81,960
(Elminated on P3, L17 C7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 81,960
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting	$ 9,450
Koch Consultants, Ltd.	Accounting	22,977
Ability Network, Inc.	Data Management	1,513
US Bank	Bond Issuance Service Fees	500
Goranson Consulting	Employee assessment	1,300
HR Fit, LLC	HR assessment and training	4,442
Management Performance Assoc.	Consulting	2,100
Peoria County	Data Processing	588,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 630,282

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,183
Unemployment Compensation Insurance	2,648
FICA Taxes	529,126
Employee Health Insurance	189,725
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	805,316
Tuition Reimbursement	3,348
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,580,346

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,013
Health Care Worker Background Check	
(Indicate # of checks performed 15)	338
Patient Background Checks 338	3,460
LeadingAge of Illinois	15,087
Miscellaneous Dues & Subscriptions	588
Books/Periodicals	141
Less: Lobbying Dues	(2,414)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,213

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,745
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,745

**See instructions.

Facility Name: **Tabor Hills Health Care Facility, Inc.**
IDPH License ID Number: **0040543**
Fiscal Year End: **1/0/1900**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	630,282
Allocated from County IT User Fees	(97,259)
Allocated from County Professional Fees	298,390
Less: Non-Allowable Legal Fees	
Total (agree to Schedule V, line 19, column 8)	831,413

Facility Name & ID Number Heddington Oaks # 0052357 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LeadingAge of Illinois $15,087**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **105,835** 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. $ **434,129**
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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **7,499**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees