

Facility Name & ID Number Heartland Manor Nursing Center

0002923 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	81	Skilled (SNF)	81	29,565	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	81	TOTALS	81	29,565	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,166	8,918	2,627	19,711	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,166	8,918	2,627	19,711	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.67%

D. How many bed reserve days during this year were paid by the Department?

None (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)

Meals on Wheels

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

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 NO

I. On what date did you start providing long term care at this location?

Date started 12/16/64

J. Was the facility purchased or leased after January 1, 1978?

YES Date N/A NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 35 and days of care provided 2,627

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	250,681	24,214	6,003	280,898		280,898	-	280,898		1
2	Food Purchase		165,300		165,300		165,300	(25,358)	139,942		2
3	Housekeeping	88,290	16,390	308	104,988		104,988	-	104,988		3
4	Laundry	43,399	8,536	817	52,752	-	52,752	-	52,752		4
5	Heat and Other Utilities			103,728	103,728		103,728	-	103,728		5
6	Maintenance	56,318	7,166	36,012	99,496		99,496	-	99,496		6
7	Other (specify):* Trash/Waste Disposal	-	-	3,807	3,807		3,807	-	3,807		7
8	TOTAL General Services	438,688	221,606	150,675	810,969	-	810,969	(25,358)	785,611		8
	B. Health Care and Programs										
9	Medical Director	-	-	7,200	7,200		7,200	-	7,200		9
10	Nursing and Medical Records	1,170,868	71,201	7,065	1,249,134		1,249,134	-	1,249,134		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	51,278	2,810	1,542	55,630		55,630	-	55,630		11
12	Social Services	29,909	-	1,542	31,451		31,451	-	31,451		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):*	-	-	-	-		-	-	-		15
16	TOTAL Health Care and Programs	1,252,055	74,011	17,349	1,343,415	-	1,343,415	-	1,343,415		16
	C. General Administration										
17	Administrative	59,417	-	-	59,417		59,417	-	59,417		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			143,339	143,339		143,339	(8,808)	134,531		19
20	Dues, Fees, Subscriptions & Promotions			33,451	33,451		33,451	(2,019)	31,432		20
21	Clerical & General Office Expenses	121,066	10,407	25,801	157,274		157,274	(2,053)	155,221		21
22	Employee Benefits & Payroll Taxes			364,231	364,231		364,231	8,062	372,293		22
23	Inservice Training & Education			-	-		-	-	-		23
24	Travel and Seminar			3,086	3,086		3,086	-	3,086		24
25	Other Admin. Staff Transportation		-	3,907	3,907		3,907	-	3,907		25
26	Insurance-Prop.Liab.Malpractice			50,705	50,705		50,705	-	50,705		26
27	Other (specify):*	-	-	-	-		-	-	-		27
28	TOTAL General Administration	180,483	10,407	624,520	815,410	-	815,410	(4,818)	810,592		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,871,226	306,024	792,544	2,969,794	-	2,969,794	(30,176)	2,939,618		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			75,860	75,860		75,860	9,796	85,656		30
31	Amortization of Pre-Op. & Org.			-	-		-	-	-		31
32	Interest			45,934	45,934		45,934	(443)	45,491		32
33	Real Estate Taxes			4,555	4,555		4,555	(4,555)	-		33
34	Rent-Facility & Grounds			-	-		-	-	-		34
35	Rent-Equipment & Vehicles			17,361	17,361		17,361	-	17,361		35
36	Other (specify):*			-	-		-	-	-		36
37	TOTAL Ownership			143,710	143,710	-	143,710	4,798	148,508		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	-	-		-	-	-		38
39	Ancillary Service Centers	-	82,182	481,445	563,627		563,627	-	563,627		39
40	Barber and Beauty Shops	-	-	-	-		-	-	-		40
41	Coffee and Gift Shops	-	-	-	-		-	-	-		41
42	Provider Participation Fee			148,668	148,668		148,668	-	148,668		42
43	Other (specify):* Non-Allowable Cos	-	-	212,931	212,931		212,931	(212,931)	-		43
44	TOTAL Special Cost Centers	-	82,182	843,044	925,226	-	925,226	(212,931)	712,295		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,871,226	388,206	1,779,298	4,038,730	-	4,038,730	(238,309)	3,800,421		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(4,099)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,796	30		9
10	Interest and Other Investment Income	(766)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,506)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(189,663)	43		24
25	Fund Raising, Advertising and Promotional	(6,577)	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	(37,494)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (238,309)		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (238,309)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 7/1/16

Ending: 6/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Ancillary Expense	\$ (12,592)	43	1
2	Non Care Real Estate Taxes	(4,570)	33	2
3	Revenue Offset to Food	(17,296)	2	3
4	Nonallowable PAC Dues	(1,606)	20	4
5	Revenue Offset to Misc Exp	(1,355)	21	5
6	Chamber & Rotary Dues	(90)	20	6
7	Insrease Property Tax Accrual	15	33	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(37,494)		49

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
N/A	N/A	N/A		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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	N/A		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/1/16 Ending: 6/30/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bruce Brown	President	Administrative	0.00	N/A	N/A	N/A	N/A	\$ N/A	N/A	1
2	Marcia Vidoni	Vice-President	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	2
3	Erik Huddlestun	Secretary	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	3
4	Sarah Holsapple-Miller	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	4
5	Mike Kirk	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	5
6	Ginny Collins-Knierim	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	6
7	Bob Dougherty	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	NA	7
8											8
9	*None of the board members have conducted business with the facility.										9
10	*None of the board members have businesses that have conducted business with the facility.										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 Heartland Manor Nursing Center

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3		N/A							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	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Preferred Bank		X	Technology	\$1,266.93	12/19/14	\$ 66,200	\$ 35,412	12/19/19	0.0550	\$ 2,457	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Preferred Bank		X	Line of Credit	None	10/28/2016	1,000,000	803,701	4/28/2018	0.0550	43,189	6								
7												7								
8	Various		X	Finance Charges							288	8								
9	TOTAL Facility Related				\$1,266.93		\$ 1,066,200	\$ 839,113			\$ 45,934	9								
B. Non-Facility Related*																				
10												10								
11								Finance Charges			(288)	11								
12								Interest Income			(155)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (443)	14								
15	TOTALS (line 9+line14)						\$ 1,066,200	\$ 839,113			\$ 45,491	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.)

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0002923

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Ending:

6/30/17

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.

2016

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.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)

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.)

Alloc Fr. Mgmt Co.

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.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>N/A</u>	8
	2013		9
	2014		10
	2015		11
	2016		12

Facility is a not for profit entity and is exempt from real estate taxes.

Real estate taxes are paid on non care assets; however, the tax is adjusted out of the cost report per instructions.

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 Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT Penny Chrysler, Administrator

TELEPHONE (217) 932-4081 FAX #: (217) 932-4922

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>Facility pays real estate taxes on non-care assets; all</u>	<u>costs are adjusted out of cost repor</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. <u>03-11-19-08-203-046</u>	<u>Lots 8&9 Sturdevant & Goble Addtn</u>	\$ 394.78	\$ _____
5. <u>03-11-19-08-203-047</u>	<u>Lots 4&5 Sturdevant & Goble Addtn</u>	\$ 2,098.86	\$ _____
6. <u>03-11-19-08-203-049</u>	<u>Lot 2 Sturdevant & Goble Addtn</u>	\$ 2,060.92	\$ _____
7. <u>09-36-700-004</u>	<u>SW NE L: RRUSK2&3</u>	\$ 15.42	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,569.98</u>	\$ _____

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? X YES NO

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

C. Tax Bills

Attach a copy of the original 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.**

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6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>152,472</u>	<u>1964</u>	<u>\$ 24,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	152,472		\$ 24,000	3

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	60	1964	1964	\$ 385,838	\$ -	25	\$ -	\$ 385,838
5		1966	1966	8,491	-	25	-	8,491
6		1970	1970	3,400	-	25	-	3,400
7		1972	1972	11,798	-	25	-	11,798
8	21	1996	1996	828,949	20,724	40	20,724	435,205
Improvement Type**								
9	Building improvements		1973	7,123		10		7,123
10	Building improvements (less disposition of \$1,076 in '07-'08)		1974	27,871		14-30		27,871
11	Building improvements (less disposition of \$1,773 in 2005-06)		1975	5,291		10-30		5,291
12	Building improvements		1976	1,607		10-30		1,607
13	Building improvements		1977	1,808		7		1,808
14	Building improvements (less disposition of \$4,880 in 2006-07)		1978	1,281		5-15		1,281
15	Building improvements		1979	949		10		949
16	Building improvements		1980	5,829		7		5,829
17	Building improvements		1981	1,376		7		1,376
18	Building improvements		1982	11,926		3-30		11,926
19	Building improvements		1983	6,263		5		6,263
20	Building improvements (less disposition of \$1,974 in 2004-05)		1984	16,740		5-15		16,740
21	Building improvements (less disposition of \$480 in 2005-06)		1985	5,320		5-15		5,320
22	Building improvements (less disposition of \$28,007 in 2005-06)		1986	17,785		10-20		17,785
23	Building improvements (less disposition of \$157 in 2006-07)		1987	27,530		5-15		27,530
24	Building improvements		1988	4,282		12-15		4,282
25	Building improvements (less disposition of \$610 in '07-'08)		1989	2,259		15		2,259
26								
27	Building improvements (less disposition of \$2,795 in 2002-03)		1991	631		10		631
28	Heating/air system		1992	80,277		20		80,277
29	Building improvements		1992	3,084		10		3,084
30	Building improvements		1992	2,168		10		2,168
31								
32	Building improvements		1992	647		10		647
33	Building improvements		1992	4,263		15		4,263
34	Ceiling/floor		1992	49,923		20		49,923
35	Sprinkler system		1992	60,121		20		60,121
36	Storage shelving		1993	4,090		10		4,090

*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 Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Storage shelving	1993	\$ 1,003	\$	10	\$	\$	\$ 1,003	37
38	Resident security system	1993	3,909		20			3,909	38
39	Cabinets	1993	42,611		15-20			42,611	39
40	Heating/air/tubs	1993	29,226		20			29,226	40
41	Fire alarm system	1993	12,350		20			12,350	41
42	Plumbing and water system	1993	8,684		20			8,684	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493		20			10,493	44
45	Building improvements	1995	22,859		10-20			22,859	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		37,888	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		15,409	48
49	Sprinklers	1996	9,774	244	40	244		4,880	49
50	Painting	1996	4,052	101	40	101		1,883	50
51	General contractor fees	1996	7,841	196	40	196		3,920	51
52	Electrical	1996	18,390	460	40	460		8,987	52
53	Chapel work - New Hutton	1996	12,572	105	40	99	(6)	12,572	53
54	Cubicle curtain tracking	1996	742		20			742	54
55	Room signs	1996	3,331		20			3,331	55
56	Emergency lighting Jones wing	1996	142		20			142	56
57	Bath systems Jones wing	1996	8,610		20			8,610	57
58	Sprinklers Jones wing	1996	340		10			340	58
59	Security locks Jones wing	1996	1,049		20	6	6	1,049	59
60									60
61	Call lights Jones wing	1996	1,881		11	1	1	1,881	61
62	Air filtration Jones wing	1996	2,081		20	1	1	2,081	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750		10			750	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		2,357	65
66	Plumbing	1996	4,640	32	20		(32)	4,640	66
67	Electrical work (less disposition of \$1,500 in 2005-06)	1996	3,162		20			3,162	67
68	Flooring	1996	2,400	20	20	20		2,400	68
69	Courtyard	1996	2,766	11	20	14	3	2,766	69
70	TOTAL (lines 4 thru 69)		\$ 1,919,114	\$ 24,638		\$ 24,611	\$ (27)	\$ 1,450,839	70

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,919,114	\$ 24,638		\$ 24,611	\$ (27)	\$ 1,450,839	1
2	Concrete work entrance	1996	1470	6	20	8	2	1,470	2
3	Building appraisal	1997	2578	64	40	64		576	3
4	Chapel HVAC	1997	2324	54	20	57	3	2,324	4
5	Stained glass window	1997	2052	68	20	74	6	2,052	5
6	Steel door	1997	422	16	20	18	2	422	6
7									7
8									8
9	Hand rails	1997	5252	263	20	260	(3)	5,252	9
10									10
11	Walk in cooler	1997	11524	576	20	576		11,474	11
12	Fire system work	1997	513	26	20	26		512	12
13	Key pad - security system	1997	360	18	20	18		357	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		889	15
16									16
17	Bed light installation	1998	1826	91	20	91		1,762	17
18	Hand rails	1998	1413	71	20	71		1,363	18
19	Sprinklers	1998	708	35	20	35		678	19
20	Generator bypass switch	1998	1567	78	20	78		1,499	20
21									21
22	Lighting - kitchen	1998	985		20			546	22
23	Paging system	1998	516	26	20	26		490	23
24	Room divider remodeling	1998	391	20	20	20		374	24
25	Bathroom lighting	1998	1090	27	20	55	28	1,030	25
26	South wing remodeling	1998	165	8	20	8		80	26
27	Roof over generator room	1998	568	28	20	28		531	27
28	Bathrooms	1998	7394	370	20	370		6,935	28
29	Bathrooms-South & Hutton	1998	6197	310	20	310		5,770	29
30	Fire Alarm System	1999	1317	66	20	66		1,203	30
31	Fire & Smoke Dampers	1999	1664	83	20	83		1,503	31
32		1999	1760	44	20	88	44	1,599	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,974,070	\$ 27,031		\$ 27,086	\$ 55	\$ 1,501,530	34

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,974,070	\$ 27,031		\$ 27,086	\$ 55	\$ 1,501,530	1
2	Generator panel	2000	2,023		10			2,023	2
3	Gazebo	2000	2,733		10			2,733	3
4	Anti-scald valves (2)	2001	655		10			655	4
5	Shower floor replacement	2001	500	25	20	25		413	5
6	Dining room lights	2001	6,013	150	20	301	151	4,964	6
7									7
8	Toilet stools & seats	2001	1,414		10			1,414	8
9	Parking lot asphalt reseal	2001	5,032	252	20	251	(1)	3,957	9
10	Ceramic wall tile	2001	365	18	20	18		285	10
11	Washer & nurse call	2001	485		10			485	11
12	Bath fans	2001	150		10			150	12
13	Extend legs on links	2001	607		10			607	13
14	Wallpaper front lobby	2001	150		10			150	14
15	Remodel North & South showers	2002	2,332	117	20	116	(1)	1,773	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912		10			912	16
17	Water heater	2002	4,165	104	20	208	104	3,139	17
18									18
19	Compressor - freezer	2002	810		10			810	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		525	20
21	Carpet	2003	2,887	144	20	144		2,126	21
22	Bypass switch for generator	2003	2,166	108	20	108		1,531	22
23	Sign	2003	850		10			850	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		2,570	25
26	Water Heater	2004	6,548	327	20	327		4,444	26
27	Wireless Monitoring System	2004	4,263		10			4,263	27
28	Water heater	2004	3,475	174	20	174		2,333	28
29	Lights, smoke detectors, other	2004	2,562		10			2,562	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		\$ 2,033,608	\$ 28,691		\$ 28,999	\$ 308	\$ 1,547,204	34

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,033,608	\$ 28,691		\$ 28,999	\$ 308	\$ 1,547,204	1
2	Security fence (less disposition of \$2,352 in 2005-06)	2005							2
3	Windows - North wing	2005	5,320	266	20	266		3,436	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		3,438	4
5	Windows - South Wing	2005	5,499	275	15	275		3,506	5
6	Windows - H Wing	2005	4,132	207	20	207		2,621	6
7	Handrails	2005	1,375	92	20	92		1,156	7
8	2 ton compressor	2005	558	37	15	37		520	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		7,696	10
11	Generator	2005	20,000		10			20,000	11
12									12
13	Roof	2006	10,657	182	39	273	91	3,003	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		1,665	14
15									15
16	Roof Repair	2008	4,587	164	27.5	167	3	1,503	16
17									17
18	Canopy Sprinkler System	2008	9,685	646	15	646		5,706	18
19	Jones Wing Door Alarms	2008	3,706	124	15	247	123	2,120	19
20	Hutton Wing New Doors	2009	5,100	340	15	340		2,890	20
21									21
22	Light Fixtures-All Areas	2010	19,737	1,038	20	987	(51)	6,991	22
23									23
24	Water Heater	2011	4,153	208	20	208		1,352	24
25	Door	2011	2,955	148	15	197	49	1,281	25
26									26
27	Backup Generator Meter	2011	3,467	173	20	173		952	27
28									28
29	Kitchen A/C Unit	2012	7,084	472	15	472		2,596	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,161,456	\$ 34,166		\$ 34,689	\$ 523	\$ 1,619,636	34

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 2,161,456	\$ 34,166		\$ 34,689	\$ 523	\$ 1,619,636		1
2									2
3	Water Heater	2013 4,385	219	20	219		986		3
4	Generator Transfer Switch	2013 2,965	148	20	148		666		4
5	Condensing Unit for Walkway	2013 4,768	318	15	318		1,431		5
6									6
7	Landscaping & fountain in front of facility	2014 7,280	364	20	364		1,274		7
8	Installation of digital phone system	2014 6,262	1,252	5	1,252		4,383		8
9	Wiring and labor for installation of EHR capability	2014 7,241	362	20	362		1,267		9
10	Replace condenser on A/C - Dining Room Area	2014 3,323	147	20	166	19	582		10
11	Front office remodel: carpet, paint & tiling	2014 3,157	23	20	158	135	552		11
12									12
13	Water Softener - Mechanical Room	2014 2,642	132	10	132	0	396		13
14	Water Heater Southwest Shower	2014 4,385	219	10	219	0	658		14
15									15
16	Roof	2017 121,884	1,042	39	1,563	521	1,563		16
17									17
18									18
19									19
20									20
21									21
22									22
23	To reconcile to financial statements		25,816			(25,816)			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)	\$ 2,329,748	\$ 64,208		\$ 39,590	\$ (24,618)	\$ 1,633,394		34

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

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	\$ 196,525	\$ 10,252	\$ 44,666	\$ 34,414	3-20 years	\$ 187,647	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	473,610				3-15 years	473,610	73
74								74
75	TOTALS	\$ 670,135	\$ 10,252	\$ 44,666	\$ 34,414		\$ 661,257	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	Resident Care	1994 Ford Van	1995	\$ 41,610	\$	\$	\$	5	\$ 41,610	76
77	Resident Care	2005 Chevy Venture Van	2014	7,000	1,400	1,400		5	4,900	77
78					-	-				78
79					-	-				79
80	TOTALS			\$ 48,610	\$ 1,400	\$ 1,400	\$		\$ 46,510	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,072,493	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,860	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,656	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,796	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,341,161	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	See Schedule 13A Attached	\$ 122,900	\$ 1,092	\$ 106,215	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 122,900	\$ 1,092	\$ 106,215	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: Heartland Manor
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2017

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Aklinski Building	1994	40,045	1,027		(1,027)		23,360
	Aklinski concrete work	1994	3,900	65		(65)		3,900
	Land		30,000			-		30,000
	Architect fees for Assisted Living	2005	2,915			-		2,915
	410 NW 3rd Street - Land		46,040			-		46,040
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			122,900	1,092	-	-		106,215

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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 17,361 Description: Please see SCH 14A

(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			\$	\$	17
18					18
19			<u>N/A</u>		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: Heartland Manor
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Dishwasher	896
Washer/Dryer	668
Oxygen Equipment	11,012
Wound Vac	4,135
CPM Units	650
Total - Line 16	<u>17,361</u>

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	<u>Ln 39, C3</u>	hrs	\$	2,452	\$ 144,506	\$	2,452	\$ 144,506	1
2	Licensed Speech and Language Development Therapist	<u>Ln 39, C3</u>	hrs		763	39,191		763	39,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	<u>Ln 39, C3</u>	hrs		4,624	297,748		4,624	297,748	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	<u>L39, C2</u>	# of prescrpts				75,635		75,635	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Resp Ther Supplies</u>	<u>L39, C2</u>					6,547		6,547	12
13	Other (specify):									13
14	TOTAL			\$	7,839	\$ 481,445	\$ 82,182	7,839	\$ 563,627	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 74,456	\$ 74,456	1
2	Cash-Patient Deposits	13,502	13,502	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>804,957</u>)	1,135,168	1,135,168	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,359	26,359	6
7	Other Prepaid Expenses	39,600	39,600	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Property Held for Sale</u>	20,804	20,804	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,309,889	\$ 1,309,889	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	84,585	24,000	13
14	Buildings, at Historical Cost	2,337,526	2,329,748	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	623,115	718,745	16
17	Accumulated Depreciation (book methods)	(2,207,959)	(2,341,161)	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 (spe <u>Security Deposits</u>)	334	334	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 837,601	\$ 731,666	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,147,490	\$ 2,041,555	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 447,000	\$ 447,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,602	13,602	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,122	134,122	30
31	Accrued Taxes Payable (excluding real estate taxes)	103,588	103,588	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	<u>See Schedule 17A</u>	203,154	203,154	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 901,466	\$ 901,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	839,113	839,113	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)	\$ 839,113	\$ 839,113	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,740,579	\$ 1,740,579	46
47	TOTAL EQUITY(page 18, line 24)	\$ 406,911	\$ 300,976	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,147,490	\$ 2,041,555	48

*(See instructions.)

Facility Name: Heartland Manor
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2017

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
Balance Transfer Clearing Account	76	76
Patient Refund Clearing Account	202,973	202,973
Employee Deductions - Credit Union	15	15
Unearned Room Revenue	90	90
Total - Line 36	203,154	203,154

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 716,401	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(34,147)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 682,254	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(275,343)	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)	\$ (275,343)	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)	\$ 406,911	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 7/1/16

Ending:

6/30/17

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,683,712	1
2	Discounts and Allowances for all Levels	66,266	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,749,978	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	842,880	6
7	Oxygen	918	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 843,798	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	17,296	14
15	Telephone, Television and Radio	2,802	15
16	Rental of Facility Space	6,250	16
17	Sale of Drugs	72,895	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,322	19
20	Radiology and X-Ray		20
21	Other Medical Services	38,888	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 142,453	23
D. Non-Operating Revenue			
24	Contributions	25,035	24
25	Interest and Other Investment Income***	155	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,190	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	1,968	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,968	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,763,387	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	810,969	31
32	Health Care	1,343,415	32
33	General Administration	815,410	33
B. Capital Expense			
34	Ownership	143,710	34
C. Ancillary Expense			
35	Special Cost Centers	776,558	35
36	Provider Participation Fee	148,668	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,038,730	40
41	Income before Income Taxes (line 30 minus line 40)**	(275,343)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (275,343)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,105,125	44
45	Private Pay - Net Inpatient Revenue	1,001,379	45
46	Medicare - Net Inpatient Revenue	643,474	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,749,978	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.

Facility Name: Heartland Manor
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2017

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Oil Income	613
Miscellaneous Income	1,355
Total - Line 28	<u>1,968</u>

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,792	3,099	\$ 48,912	\$ 15.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,717	8,252	182,006	22.06	3
4	Licensed Practical Nurses	17,080	18,288	349,632	19.12	4
5	CNAs & Orderlies	43,305	46,134	532,187	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,009	2,127	22,056	10.37	9
10	Activity Assistants	2,746	2,917	29,222	10.02	10
11	Social Service Workers	2,047	2,262	29,909	13.22	11
12	Dietician					12
13	Food Service Supervisor	2,012	2,179	34,179	15.69	13
14	Head Cook	7,882	8,571	83,302	9.72	14
15	Cook Helpers/Assistants	13,873	14,788	133,200	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,647	4,018	56,318	14.02	17
18	Housekeepers	9,048	9,790	88,290	9.02	18
19	Laundry	3,661	4,203	43,399	10.33	19
20	Administrator	1,988	2,052	59,417	28.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,579	6,429	91,977	14.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,897	2,099	29,089	13.86	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,174	24,630	11.33	31
32	Other Health C: <u>MDS Coordinator</u>	1,845	2,101	33,501	15.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,104	141,483	\$ 1,871,226 *	\$ 13.23	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	108	\$ 6,003	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant	12	1,560	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	88	3,255	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,542	L11, C3	44
45	Social Service Consultant	24	1,542	L12, C3	45
46	Other(specify) <u>Utilization Review</u>	Monthly	2,250	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 23,352		49

C. CONTRACT NURSES

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

Facility Name: Heartland Manor
IDPH License ID Number: 0002923
Fiscal Year End: 6/30/2017

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Quorum Consulting Group	401(k) Administrator	\$ 2,360
RSM US LLP	Accounting	\$ 106,523
Duane Morris	Legal	\$ 34,223
Personnel Planners	Consulting	\$ 233

Total (agree to Schedule V, line 19, column 3) \$ 143,339

Add: Reclass Unemployment Fees \$ 698
 Less: Non-Allowable Legal Fees (9,506)

Total (agree to Schedule V, line 19, column 8) \$ 134,531

Facility Name & ID Number Heartland Manor Nursing Center# 0002923

Report Period Beginning:

7/1/16

Ending:

6/30/17**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. Illinois Health Care Assoc. \$3,740
- (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. \$ 9,912 Line L10, C2
- (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. \$ 148,668
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. \$ 8,062 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 17,296
- (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? N/A
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: RSM US LLP
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees