



Facility Name & ID Number Heartland of Galesburg

# 0049460 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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**

	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	84	Skilled (SNF)	84	30,660	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	84	TOTALS	84	30,660	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	9,589	5,756	8,730	24,075	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,589	5,756	8,730	24,075	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 78.52%

**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  NO

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

**I. On what date did you start providing long term care at this location?**  
Date started 11/01/81

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 04/07/11 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 84 and days of care provided 4,658

Medicare Intermediary CGS Administrators, LLC

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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**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
	<b>A. General Services</b>										
1	Dietary	216,289	12,963	17,779	247,031		247,031		247,031		1
2	Food Purchase		164,872		164,872		164,872	(20,656)	144,216		2
3	Housekeeping	152,609	17,180	3,055	172,844		172,844		172,844		3
4	Laundry	21,458	17,642		39,100		39,100		39,100		4
5	Heat and Other Utilities			144,931	144,931	1,171	146,102		146,102		5
6	Maintenance	55,330	28,696	65,255	149,281		149,281		149,281		6
7	Other (specify):* <b>Medical Waste</b>			225	225		225		225		7
8	<b>TOTAL General Services</b>	445,686	241,353	231,245	918,284	1,171	919,455	(20,656)	898,799		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,360	15,360		15,360		15,360		9
10	Nursing and Medical Records	1,581,741	114,599	40,539	1,736,879	27	1,736,906		1,736,906		10
10a	Therapy	478,525	7,965	147,701	634,191		634,191		634,191		10a
11	Activities	54,152	5,180	2,107	61,439		61,439		61,439		11
12	Social Services	100,032	4	2,483	102,519		102,519		102,519		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,214,450	127,748	208,190	2,550,388	27	2,550,415		2,550,415		16
	<b>C. General Administration</b>										
17	Administrative	104,638		298,909	403,547	(144,728)	258,819		258,819		17
18	Directors Fees										18
19	Professional Services			80,613	80,613		80,613	(80,613)			19
20	Dues, Fees, Subscriptions & Promotions			55,831	55,831		55,831	(16,106)	39,725		20
21	Clerical & General Office Expenses	199,911	48,701	192,935	441,547		441,547	(128,060)	313,487		21
22	Employee Benefits & Payroll Taxes			494,598	494,598	21,686	516,284		516,284		22
23	Inservice Training & Education			2,216	2,216		2,216		2,216		23
24	Travel and Seminar			9,479	9,479		9,479		9,479		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,769	52,769		52,769		52,769		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	304,549	48,701	1,187,350	1,540,600	(123,042)	1,417,558	(224,779)	1,192,779		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,964,685	417,802	1,626,785	5,009,272	(121,844)	4,887,428	(245,435)	4,641,993		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.

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Heartland of Galesburg

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			134,916	134,916	7,188	142,104		142,104			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			705,218	705,218	114,656	819,874	(705,974)	113,900			32
33	Real Estate Taxes			151,120	151,120		151,120		151,120			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,744	39,744		39,744		39,744			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,030,998	1,030,998	121,844	1,152,842	(705,974)	446,868			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,014		216,014		216,014		216,014			39
40	Barber and Beauty Shops		189	4,647	4,836		4,836		4,836			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,538	158,538		158,538		158,538			42
43	Other (specify):* <b>IV   X-Ray &amp; Lab</b>		5,001	34,753	39,754		39,754		39,754			43
44	<b>TOTAL Special Cost Centers</b>		221,204	197,938	419,142		419,142		419,142			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,964,685	639,006	2,855,721	6,459,412		6,459,412	(951,409)	5,508,003			45

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

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**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	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20,656)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(1,072)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(195)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(75,015)	21		18
19	Entertainment				19
20	Contributions	(1,293)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(72,931)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(48,568)	21		24
25	Fund Raising, Advertising and Promotional	(16,106)	20		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 Pg. 5A	(715,573)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (951,409)		\$	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)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (951,409)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$	11	1
2	Misc. Income		21	2
3	Vending Income	(1,472)	21	3
4	Donations Revenue	(445)	21	4
5	Accounting/Collection Fees	(7,682)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(705,974)	32	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	<b>Total</b>	(715,573)		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
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HCR Manor Care Svcs	Toledo	Therapy Mgmt Svcs
				HL Home Health Care	Toledo	Nursing Staff

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	See Home Office Allocation	\$ 298,909	HCR Manor Care Services, LLC	0.00%	\$ 298,909	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	2,964,685	Heartland Employment Services, LLC	0.00%	2,964,685		4
5	V	10a Therapy Management	11,354	Heartland Rehabilitation Services, LLC	0.00%	11,354		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		\$ 3,274,948			\$ 3,274,948	\$ *	14

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

Facility Name &amp; ID Number

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## 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			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				12
13			Manor Care of Hinsdale IL, LLC	Hinsdale				13
14			Manor Care of Homewood IL, LLC	Homewood				14
15			Manor Care of Libertyville IL, LLC	Libertyville				15
16			Manor Care of Naperville IL, LLC	Naperville				16
17			Manor Care of Northbrook IL, LLC	Northbrook				17
18			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				18
19			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				19
20			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				20
21			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				21
22			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				22
23			Manor Care of South Holland IL, LLC	South Holland				23
24			Manor Care of Westmont IL, LLC	Westmont				24
25			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				25
26			Arden Courts of Geneva IL, LLC	Geneva				26
27			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				27
28			Arden Courts of Northbrook IL, LLC	Northbrook				28
29			Arden Courts of Palos Heights IL, LLC	Palos Heights				29
30			Arden Courts of South Holland IL, LLC	South Holland				30

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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	N/A								\$	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

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization HCR Manor Care Services LLC  
 Street Address 333 North Summit Street  
 City / State / Zip Code Toledo, OH 43604-2617  
 Phone Number ( 419) 252-5500  
 Fax Number ( 419) 254-5495

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	5	Utilities - Pooled	Accumulated Cost	560 NFs, HHs, & Re	\$ 699,205	\$ 0	6,258,258	\$ 1,171	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	359 NFs	0	0	6,258,258	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	6,258,258	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	560 NFs, HHs, & Re	16,031	10,238	6,258,258	27	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	359 NFs	0	0	6,258,258	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	6,258,258	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	560 NFs, HHs, & Re	59,973,786	32,867,234	6,258,258	100,408	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	359 NFs	16,450,188	6,362,586	6,258,258	31,722	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	72 NFs	2,602,958	0	6,258,258	22,051	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	560 NFs, HHs, & Re	5,900,308	0	6,258,258	9,878	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	359 NFs	6,123,085	0	6,258,258	11,808	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	72 NFs	0	0	6,258,258	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	560 NFs, HHs, & Re	3,462,953	0	6,258,258	5,797	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	359 NFs	721,157	0	6,258,258	1,391	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	6,258,258	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,591,078		6,258,258	47,867	22
23	32	Directly Assigned Interest	Not Allocated		16,243,764			66,789	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			34,016,444				24
25	TOTALS				\$ 174,800,956	\$ 39,240,058		\$ 298,909	25

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**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Conv. Sub. Debentures		X				\$ 964,387	\$ 863,012			0.0774	\$ 66,789						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6	Home Office Pooled Interest Expense											47,867						
7	Interest Income / Interest Expense											(756)						
8																		
9	<b>TOTAL Facility Related</b>						\$ 964,387	\$ 863,012				\$ 113,900						
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 964,387	\$ 863,012				\$ 113,900						

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

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

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



**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heartland of Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049460

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

**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>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>99-10-427-018</u>	<u>See Attached</u>	\$ <u>144,434.42</u>	\$ <u>144,434.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>144,434.42</u></u>	\$ <u><u>144,434.42</u></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?        YES   X   NO

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

**C. Tax Bills**

Attach a copy of the original 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 Heartland of Galesburg

# 0049460 Report Period Beginning:

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,388 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983 & 2003	\$ 121,935	1
2	Facility		2006	47,025	2
3	TOTALS			\$ 168,960	3

Facility Name & ID Number Heartland of Galesburg

# 0049460

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**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69	1964	1964	\$ 407,801	\$ 35,392		\$ 35,392		\$ 863,769	4
5	7		2003	570,110						5
6	7/1/06 Capital Rate Adj #1		2003	81,936						6
7	8		2005	637,826						7
8	7/1/06 Capital Rate Adj #14		2005	125,742						8
<b>Improvement Type**</b>										
9	Current Year Depreciation				65,440		65,440		2,328,414	9
10	Building Improvements		1968	73						10
11	Building Improvements		1969	1,059						11
12	Building Improvements		1970	1,083						12
13	Building Improvements		1971	10,602						13
14	Building Improvements		1972	5,946						14
15	Building Improvements		1973	758						15
16	Building Improvements		1974	817						16
17	Building Improvements		1975	3,645						17
18	Building Improvements		1978	19,333						18
19	Land Improvements		1983	1,350						19
20	Building Improvements		1984	21,913						20
21	Building Improvements		1985	42,479						21
22	Land Improvements		1985	8,457						22
23	Building Improvements		1986	23,347						23
24	Land Improvements		1986	2,349						24
25	Building Improvements		1987	19,172						25
26	Building Improvements		1988	14,265						26
27	Land Improvements		1988	1,470						27
28	Building Improvements		1989	36,615						28
29	Land Improvements		1990	1,500						29
30	Building Improvements		1990	27,793						30
31	Building Improvements		1991	9,501						31
32	Building Improvements		1992	24,536						32
33	Building Improvements		1993	16,600						33
34	Land Improvements		1994	3,095						34
35	Building Improvements		1994	1,278						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 &amp; ID Number Heartland of Galesburg

# 0049460

Report Period Beginning:

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Ending:

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## 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	Land Improvements	1995	\$ 1,098	\$		\$	\$	\$	37
38	Building Improvements	1995	14,214						38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693						39
40	engineering fees, demolition, masonry, concrete, drywall,								40
41	windows, doors, wood trim, paint, counter tops, electrical								41
42	Building Improvements : Wallcovering	1996	79,684						42
43	Building Improvements : Carpet and vinyl	1996	33,131						43
44	Building Improvements : Ceramic flooring	1996	40,886						44
45	Building Improvements : Millwork	1996	25,990						45
46	AUDIT ADJ 7/1/03 (#1) - PG 12A, LINE 45 (1996)	1996	(627)						46
47	Building Improvements : Electrical lighting, plumbing fixtures, ha	1996	51,580						47
48	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,								48
49	vinyl flooring								49
50	Building Improvements : Doors	1997	10,728						50
51	Building Improvements : Electrical composite, automatic doors,	1997	38,947						51
52	metal doors, fire alarm system								52
53	Building Improvements : Capalo	1997	2,500						53
54	Building Improvements : Generator	1997	7,743						54
55	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556						55
56	Building Improvements : Onan Genator	1997	17,482						56
57	Building Improvements : Soffits, gutters & trim	1997	9,962						57
58	Building Improvements : Generator	1997	24,885						58
59	Building Improvements - HVAC	1997	42,499						59
60	Land Improvements - Sidewald	1998	7,988						60
61	Building Improvements - Fire Prevention System	1998	35,013						61
62	Sidewalk	1999	7,988						62
63	Sidewalk	1999	900						63
64	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 62	1999	(900)						64
65	Overhead from const	1999	2,681						65
66	AUDIT ADJ 7/1/03 (#2) - PG 12A, LINE 63	1999	(2,681)						66
67	Power control wiring for ne	1999	2,392						67
68	Sprinkler system upgrade	1999	19,107						68
69	AUDIT ADJ 7/1/03 (#3) - PG 12A, LINE 65	1999	(1,740)						69
70	TOTAL (lines 4 thru 69)		\$ 3,084,150	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	70

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

Facility Name & ID Number Heartland of Galesburg# 0049460

Report Period Beginning:

01/01/17

Ending:

12/31/17**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,084,150	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	1
2	Air compressor	1999	598						2
3	Laundry room floor	1999	1,800						3
4	Sprinkler upgrade	1999	23,940						4
5	Fire sprinkler system	1999	2,971						5
6	Boiler	1999	33,600						6
7	HVAC upgrade	1999	2,420						7
8	Building improvements	1999	1,200						8
9	SMOKING HUT	2000	4,950						9
10	CONCRETE FOR SMOKE HUT	2000	350						10
11	CABINETRY	2000	3,690						11
12	ELECTRICAL	2000	20,205						12
13	ADDT'L COST SMOKING HUT	2000	645						13
14	ELECTRICAL	2000	10,880						14
15	ELECTRICAL	2000	3,454						15
16	HVAC	2000	21,662						16
17	ELECTRICAL/NEW OFFICE	2000	860						17
18	CABINETS	2000	1,369						18
19	HVAC	2000	1,736						19
20	HVAC	2000	193						20
21	ADDT'L COST FOR SPRINKLER SYST	2000	15,146						21
22	AUDIT ADJ 7/1/03 (#4) - PG 12B, LINE 18	2000	(15,146)						22
23	AIR / HUMIDIFIER COIL	2001	5,233						23
24	CANOPY	2001	1,200						24
25	CONCRETE PATIO	2001	5,500						25
26	Roof Upgrade - AUDIT ADJ 7/1/03 (#5) - CHG YEAR	2001	98,494						26
27	AUDIT ADJ 7/1/03 (#6) - PG 12B, LINE 24	2001	(6,839)						27
28	VWC	2002	1,172						28
29	Carpet	2002	1,534						29
30	Border	2002	111						30
31	Border	2002	125						31
32	Brick Work	2002	5,787						32
33	Addition Cost Brick Work	2002	643						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,333,633	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	34

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

Facility Name &amp; ID Number Heartland of Galesburg

# 0049460

Report Period Beginning:

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## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,333,633	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	1
2	Artwork	2002	2,219						2
3	AUDIT ADJ 7/1/03 (#7) - PG 12B, LINE 29	2002	(2,219)						3
4	Paint & Wallcovering	2002	2,810						4
5	Paint & Wallcovering	2002	3,122						5
6	Carpet & Painting - AUDIT ADJ 7/1/03 (#9) - CHG YEAR	2002	34,932						6
7	Overhead & Interest	2003	431						7
8	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 32	2003	(431)						8
9	Paint, Flooring & VWC	2003	12,182						9
10	Paint, Flooring & VWC	2003	1,354						10
11	Freight on Carpet	2003	56						11
12	Carpet, Wallcovering and Corner Guards	2003	12,197						12
13	Developers Costs - Architect & Engineering Fees	2003	96,312						13
14	7/1/06 Capital Rate Adj #4	2003	(10,839)						14
15	7/1/06 Capital Rate Adj #5	2003	(17,967)						15
16	Developers Costs - T&E, Reprod.,Permit & Plan Review Fees	2003	15,798						16
17	7/1/06 Capital Rate Adj #6	2003	(5,436)						17
18	Developers Costs - Overhead	2003	152,775						18
19	7/1/06 Capital Rate Adj #7	2003	(152,775)						19
20	Developers Costs - Interest	2003	13,748						20
21	7/1/06 Capital Rate Adj #8	2003	(13,748)						21
22	Millwork	2003	4,664						22
23	Soil and Concrete Testing, Water & Sewer Fees	2003	6,851						23
24	7/1/06 Capital Rate Adj #2	2003	(6,851)						24
25	Site Work/Preparation	2003	74,492						25
26	7/1/06 Capital Rate Adj #3	2003	(74,492)						26
27	CONSULTING SERVICES-PHASE 2 ADDITION	2003	3,200						27
28	ARCHITECTURAL SERVICES	2003	9,117						28
29	ENGINEERING COST-CENTRAL BATH RENOV	2004	4,013						29
30	ENGINEERING COST-CENTRAL BATH RENOV	2004	6,479						30
31	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	723						31
32	ARCHITECTURAL COST-CENTRAL BATH RENOV	2004	180						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,506,530	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	34

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

Facility Name &amp; ID Number Heartland of Galesburg

# 0049460

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,506,530	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	1
2	ENGINEERING COST-CENTRAL BATH RENOV	2004	450						2
3	VINYL WALL COVERING	2004	266						3
4	BORDER	2004	948						4
5	ARCHITECTURAL COSTS-CENTRAL BATH RENOV	2004	2,986						5
6	BORDER FOR BATH	2004	85						6
7	ENGINEERING COST-CENTRAL BATH RENOV	2004	2,794						7
8	CARPET & COVE BASE	2004	6,273						8
9	VINYL WALL COVERING	2004	8,199						9
10	GAZEBO	2004	6,389						10
11	MATERIAL & SVCS-NURSING STA & BATH	2004	93,206						11
12	VINYL WALL COVERING	2005	497						12
13	GENERAL CONTRACTOR	2005	117,042						13
14	7/1/06 Capital Rate Adj #9	2005	(117,042)						14
15	SOIL TESTING	2005	1,790						15
16	7/1/06 Capital Rate Adj #10	2005	(1,790)						16
17	GAS SERVICE	2005	321						17
18	7/1/06 Capital Rate Adj #11	2005	(321)						18
19	SOIL TESTING	2005	3,370						19
20	7/1/06 Capital Rate Adj #12	2005	(3,370)						20
21	CONCRETE TESTING	2005	2,555						21
22	7/1/06 Capital Rate Adj #13	2005	(2,555)						22
23	GENERAL OVERHEAD	2005	8,273						23
24	7/1/06 Capital Rate Adj #15	2005	(8,273)						24
25	INTEREST ON CONSTRUCTION	2005	426						25
26	7/1/06 Capital Rate Adj #16	2005	(426)						26
27	CARPETING & PADS	2005	708						27
28	WALL COVERING	2005	4,135						28
29	CARPENTRY	2005	68,875						29
30	DRYWALL/STUDS	2005	1,500						30
31	DOORS/FRAMES	2005	1,125						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,704,966	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	34

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

Facility Name &amp; ID Number Heartland of Galesburg

# 0049460

Report Period Beginning:

01/01/17

Ending:

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## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 3,704,966	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	1
2	ARCHITECT & ENGINEER COST	2005	59,040						2
3	ARCHITECT & ENGINEER COST	2005	8,988						3
4	ENGINEERING - CIVIL	2005	9,080						4
5	ENGINEERING - ELECTRIC	2005	600						5
6	LANDSCAPE DESIGN CONTRACTOR	2005	12,705						6
7	OVERHEAD	2005	106,428						7
8	7/1/06 Capital Rate Adj #18	2005	(106,428)						8
9	PERMIT FEES	2005	2,825						9
10	PLAN REVIEWS	2005	8,271						10
11	7/1/06 Capital Rate Adj #19	2005	(8,271)						11
12	INTEREST ON CONSTRUCTION	2005	16,467						12
13	7/1/06 Capital Rate Adj #20	2005	(16,467)						13
14	CARPETING AND PADS	2005	2,835						14
15	WALL COVERING	2005	9,095						15
16	CORNER GUARDS	2006	225						16
17	FIRE PROTECTION PIPING	2006	600						17
18	BASIC ELECTRICAL	2006	490						18
19	WALLCOVERINGS	2006	1,215						19
20	3 SETS OF DOORS	2006	4,226						20
21	INSTALL GUTTERS/WINDOWS	2006	14,500						21
22	VINYL WALL COVERING	2006	150						22
23	GUTTERS	2006	2,025						23
24	FLOORING-KITCHEN STORAGE	2006	6,278						24
25	EXPAND FREEZER & COOLER	2006	30,957						25
26	DOOR	2006	3,041						26
27	SIDEWALKS	2007	6,879						27
28	SIDEWALKS	2007	2,106						28
29	boiler room door	2007	2,419						29
30	Fire Sprinkler System	2007	2,728						30
31	Architecture for Concrete	2007	1,739						31
32	LAUNDRY RM IMP-DRYWALL, PAINT & DOORS	2007	11,516						32
33	DOOR LEADING TO KITCHEN	2007	2,127						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,903,355	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	34

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

Facility Name & ID Number Heartland of Galesburg# 0049460

Report Period Beginning:

01/01/17

Ending:

12/31/17**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,903,355	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	1
2	0707 NURSE STATION GEN'L OH	2007	631						2
3	0707 NURSE STATION CARPENTRY	2007	16,655						3
4	0707 NURSE STATION CABINETS	2007	12,567						4
5	HOT WATER HEATER	2008	11,677						5
6	new garage	2008	10,325						6
7	PT DOUBLE DOORS	2008	4,750						7
8	OT DOUBLE DOORS	2008	4,750						8
9	NEW GARAGE	2008	10,325						9
10	garage work	2008	1,950						10
11	Door Replacement / Renovation	2008	2,157						11
12									12
13	Concrete Ramp	2008	10,800						13
14	HVAC Controls	2009	2,540						14
15	HVAC Controls	2009	39,798						15
16									16
17	40685 Kithen door	2010	2,470						17
18	40686 front entrance awning	2010	3,198						18
19	40688 adj asset 40686-frnt ent awning	2010	3,198						19
20	40689 VCT flooring	2010	13,925						20
21	40690 add'l cost VCT flooring	2010	13,925						21
22									22
23	40701 Water Heater	2011	13,500						23
24	40702 acoustical ceiling	2011	7,200						24
25	40703 STAINLESS STEEL BACKSLACH	2011	7,650						25
26	40704 CEILING GRID IN DINING RM	2011	3,285						26
27									27
28	40712 WALL COVERING & CARPET in Front Corridor	2012	23,432						28
29	40720 BURNER ASSEMBLY FOR BOILER	2012	8,515						29
30	40721 WALLCOVERING in Front Corridor	2012	934						30
31	40722 FIRE DOOR In TV Lounge	2012	3,105						31
32	40723 WALLCOVERING in Front Corridor	2012	848						32
33	40724 WALL COVERING & CARPET-Front Corridor	2012	2,604						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,140,069	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	34

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

Facility Name &amp; ID Number Heartland of Galesburg

# 0049460

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	<b>Totals from Page 12F, Carried Forward</b>		\$ 4,140,069	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	1
2	40725 WALLCOVERING IN FRONT CORRIDOR	2012	3,713						2
3	40726 WALLCOVERING IN FRONT CORRIDOR	2012	609						3
4	40730 CONCRETE Front Bldg & SEAL COAT Parking Lot	2012	6,388						4
5	40738 Install WATER HEATER/rep HEAT Exchanger in boiler	2013	23,852						5
6	40747 LIGHTING UPGRADES	2014	7,027						6
7	40761 Shower stall repairs-installed new tile	2014	2,650						7
8	40762 Shower stall repairs-install flooring	2014	2,565						8
9									9
10	40766 Drain replaced, add flr sink in Kitchen Dishwash area	2015	6,638						10
11	40768 Floor replacement Kitchen Dishwash area	2015	6,165						11
12	40771 & 40776 Boiler - replace flue, burners, & controls	2015	14,967						12
13	40774 Repair Ktchen Wall - Studs, Durock, Paint	2015	2,565						13
14	40779 Install Firestop materials to 1st flr. smoke barriers	2015	14,874						14
15	40782 HM Doors (2) at SW exit & small dining rom	2015	3,149						15
16									16
17	Conduit & Wiring for Generator Life Safey Branch	2016	9,375						17
18	Fire Alarm System	2016	17,033						18
19	Sewer repair under concrete floor & flooring for dietary kitchen	2016	9,529						19
20	Roofing repairs to valley & flashing - installed ice guard	2016	4,997						20
21	Repair water damage Ceiling in employee break room	2016	4,114						21
22	Roof repair over cooler/freezer, east side of bldg	2016	4,822						22
23	Furnish & install Water Heater BTH-400 in mechanical room	2016	21,069						23
24									24
25	Chiller Compressor - AC unit A1 entire bldg outside Mech Rm	2017	7,500						25
26	Asphalt /striping- parking lot	2017	2,850						26
27	Tile walls in resident baths -rms 143, 145, 147	2017	2,625						27
28	Sidewalk- E side of bldg	2017	9,350						28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,328,495	\$ 100,832		\$ 100,832	\$	\$ 3,192,183	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,867,485	\$ 34,084	\$ 34,084	\$		\$ 1,773,326	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			7,188	7,188			74
75	TOTALS	\$ 1,867,485	\$ 34,084	\$ 41,272	\$ 7,188		\$ 1,773,326	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,364,936	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,916	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 142,104	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,188	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,965,509	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heartland of Galesburg

# 0049460

Report Period Beginning: 01/01/17

Ending: 12/31/17

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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: \$ 16,437 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.

(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	<u>Patient Transportation</u>	<u>2013 Ford E350 Turtle To</u>	\$ _____	\$ <u>23,307</u>	17
18					18
19				<u>above figure includes</u>	19
20				<u>gas &amp; maintenance</u>	20
21	<b>TOTAL</b>		\$ _____	\$ <u>23,307</u>	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.

**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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	10a	31 hrs	\$ 1,220	2,070	\$ 130,345	\$ 497	2,101	\$ 132,062	1
2	Licensed Speech and Language Development Therapist	10a	1447 hrs	56,938			106	1,447	57,044	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1863 hrs	73,307	105	6,599	7,362	1,968	87,268	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				216,014		216,014	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a, 3			88	5,569		88	5,569	12
13	Other (specify): <u>X-Ray &amp; Lab   IV</u>	43, 2 & 3				34,753	5,001		39,754	13
14	<b>TOTAL</b>			\$ 131,465	2,263	\$ 177,266	\$ 228,980	5,604	\$ 537,711	14

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

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,559	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (109,725) )	673,899		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,661		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 685,119	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	168,960		13
14	Buildings, at Historical Cost	4,328,491		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,867,485		16
17	Accumulated Depreciation (book methods)	(4,965,509)		17
18	Deferred Charges	94,487		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 OMIT	40,610		22
23	Other(specify): CIP			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,534,524	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,219,643	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 195,215	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,727		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	144,434		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accounts Payable	75,868		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 699,244	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	863,012		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 863,012	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,562,256	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 657,387	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,219,643	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>988,402</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>988,402</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(56,495)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (56,495)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	(274,520)	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ (274,520)	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>657,387</b>	<b>24</b> *

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

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,380,916	1
2	Discounts and Allowances for all Levels	(2,736,053)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,644,863	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,121,542	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,121,542	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,472	12
13	Barber and Beauty Care	5,417	13
14	Non-Patient Meals	20,656	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	438,372	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,124	19
20	Radiology and X-Ray	52,725	20
21	Other Medical Services	83,229	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 634,995	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	445	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 445	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Discount</u>	1,072	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,072	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,402,917	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	918,284	31
32	Health Care	2,550,388	32
33	General Administration	1,540,600	33
<b>B. Capital Expense</b>			
34	Ownership	1,030,998	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	260,604	35
36	Provider Participation Fee	158,538	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,459,412	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(56,495)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (56,495)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,331,248	44
45	Private Pay - Net Inpatient Revenue	1,189,933	45
46	Medicare - Net Inpatient Revenue	610,920	46
47	Other-(specify) <u>Hospice</u>	118,494	47
48	Other-(specify) <u>Insurance</u>	394,268	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,644,863	49

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

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

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

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

Facility Name & ID Number Heartland of Galesburg

# 0049460

Report Period Beginning: 01/01/17

Ending: 12/31/17

12/31/17

**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	2,318	2,549	\$ 99,979	\$ 39.22	1
2	Assistant Director of Nursing	4,370	4,806	150,014	31.21	2
3	Registered Nurses	10,624	11,683	308,321	26.39	3
4	Licensed Practical Nurses	17,130	18,837	364,840	19.37	4
5	CNAs & Orderlies	47,322	52,250	623,215	11.93	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	5,872	6,457	254,108	39.35	7
8	Rehab/Therapy Aides	7,258	7,983	224,417	28.11	8
9	Activity Director	2,809	3,091	54,152	17.52	9
10	Activity Assistants					10
11	Social Service Workers	3,891	4,286	100,032	23.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,954	18,683	216,289	11.58	15
16	Dishwashers					16
17	Maintenance Workers	2,288	2,524	55,330	21.92	17
18	Housekeepers	12,606	13,895	152,609	10.98	18
19	Laundry	1,885	2,078	21,458	10.33	19
20	Administrator	2,080	2,080	104,638	50.31	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,943	8,791	199,911	22.74	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	2,287	2,517	35,372	14.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,637	162,510	\$ 2,964,685 *	\$ 18.24	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	\$		35	
36	Medical Director	Monthly	15,360	9, 3	36
37	Medical Records Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	15,360		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$	10, 3	50
51	Licensed Practical Nurses		10, 3	51
52	Certified Nurse Assistants/Aides		10, 3	52
53	TOTAL (lines 50 - 52)	\$		53



Facility Name &amp; ID Number Heartland of Galesburg

# 0049460

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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. IHCA \$2,534 & AHCA \$1,233
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5-10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,401 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? YES  
If YES, give effective date of lease. 04/07/11
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 158,538  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 20,656
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
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. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (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. NO  
Attach invoices and a summary of services for all architect and appraisal fees