



Facility Name & ID Number Heartland of Macomb

# 0049585 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	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,730	2,942	6,893	23,565	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,730	2,942	6,893	23,565	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 80.70%

**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 04/01/1989

**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 80 and days of care provided 5,003

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.

Facility Name & ID Number Heartland of Maccomb # 0049585 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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
	<b>A. General Services</b>										
1	Dietary	209,869	26,493	19,718	256,080		256,080		256,080		1
2	Food Purchase		168,800		168,800		168,800	(9,884)	158,916		2
3	Housekeeping	112,046	11,584	400	124,030		124,030		124,030		3
4	Laundry	20,989	11,641		32,630		32,630		32,630		4
5	Heat and Other Utilities			91,739	91,739	1,099	92,838		92,838		5
6	Maintenance	43,166	18,879	39,256	101,301		101,301		101,301		6
7	Other (specify):* <b>Medical Waste</b>			579	579		579		579		7
8	<b>TOTAL General Services</b>	<b>386,070</b>	<b>237,397</b>	<b>151,692</b>	<b>775,159</b>	<b>1,099</b>	<b>776,258</b>	<b>(9,884)</b>	<b>766,374</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,212	8,212		8,212		8,212		9
10	Nursing and Medical Records	1,566,379	121,060	19,928	1,707,367	25	1,707,392		1,707,392		10
10a	Therapy	578,126	9,914	126,574	714,614		714,614		714,614		10a
11	Activities	55,386	3,039	320	58,745		58,745		58,745		11
12	Social Services	97,063		3,394	100,457		100,457		100,457		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,296,954</b>	<b>134,013</b>	<b>158,428</b>	<b>2,589,395</b>	<b>25</b>	<b>2,589,420</b>		<b>2,589,420</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	105,605		258,171	363,776	(113,431)	250,345		250,345		17
18	Directors Fees										18
19	Professional Services			63,508	63,508		63,508	(63,508)			19
20	Dues, Fees, Subscriptions & Promotions			77,707	77,707		77,707	(34,350)	43,357		20
21	Clerical & General Office Expenses	228,793	32,935	182,786	444,514		444,514	(133,508)	311,006		21
22	Employee Benefits & Payroll Taxes			453,891	453,891	20,358	474,249		474,249		22
23	Inservice Training & Education			6,101	6,101		6,101		6,101		23
24	Travel and Seminar			9,103	9,103		9,103		9,103		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,709	67,709		67,709		67,709		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>334,398</b>	<b>32,935</b>	<b>1,118,976</b>	<b>1,486,309</b>	<b>(93,073)</b>	<b>1,393,236</b>	<b>(231,366)</b>	<b>1,161,870</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,017,422</b>	<b>404,345</b>	<b>1,429,096</b>	<b>4,850,863</b>	<b>(91,949)</b>	<b>4,758,914</b>	<b>(241,250)</b>	<b>4,517,664</b>		<b>29</b>

\*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 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			166,120	166,120	6,748	172,868		172,868		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			623,557	623,557	85,201	708,758	(625,198)	83,560		32
33	Real Estate Taxes			59,468	59,468		59,468		59,468		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			47,303	47,303		47,303		47,303		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			896,448	896,448	91,949	988,397	(625,198)	363,199		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		154,079		154,079		154,079		154,079		39
40	Barber and Beauty Shops			4,537	4,537		4,537		4,537		40
41	Coffee and Gift Shops	25,074			25,074		25,074		25,074		41
42	Provider Participation Fee			156,835	156,835		156,835		156,835		42
43	Other (specify):* <b>IV   X-Ray &amp; Lab</b>		12,139	12,210	24,349		24,349		24,349		43
44	<b>TOTAL Special Cost Centers</b>	25,074	166,218	173,582	364,874		364,874		364,874		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,042,496	570,563	2,499,126	6,112,185		6,112,185	(866,448)	5,245,737		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	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,884)	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	(588)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(104)	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		21		18
19	Entertainment				19
20	Contributions	(1,316)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(56,746)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(131,122)	21		24
25	Fund Raising, Advertising and Promotional	(34,350)	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	(632,338)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (866,448)		\$	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>	\$ (866,448)		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	

Heartland of Macomb

ID# 0049585

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	(228)	21	3
4	Donations Revenue	(150)	21	4
5	Accounting/Collection Fees	(6,762)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(625,198)	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>	(632,338)		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	\$ 258,171	HCR Manor Care Services, LLC	0.00%	\$ 258,171	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	3,042,496	Heartland Employment Services, LLC	0.00%	3,042,496		4
5	V	10a Therapy Management	10,814	HCR Manor Care Services, LLC	0.00%	10,814		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		\$ 3,311,481			\$ 3,311,481	\$ *	14

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

Facility Name &amp; ID Number

Heartland of Macomb

# 0049585

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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 Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				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

Facility Name & ID Number Heartland of Macomb # 0049585 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	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

Facility Name & ID Number Heartland of Macomb

# 0049585

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

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

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

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, & R	\$ 699,205	\$ 0	5,875,027	\$ 1,099	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	359 NFs	-	0	5,875,027		2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	72 NFs	-	0	5,875,027		3
4									4
5	10	Nursing - Pooled	Accumulated Cost	560 NFs, HHs, & R	16,031	10,238	5,875,027	25	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	359 NFs	0	0	5,875,027	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	5,875,027	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	560 NFs, HHs, & R	59,973,786	32,867,234	5,875,027	94,259	9
10	17	General & Administrative - Direct	Accumulated Cost	359 NFs	16,450,188	6,362,586	5,875,027	29,780	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	72 NFs	2,602,958	0	5,875,027	20,701	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	560 NFs, HHs, & R	5,900,308	0	5,875,027	9,273	13
14	22	Employee Benefits - Direct to All S	Accumulated Cost	359 NFs	6,123,085	0	5,875,027	11,085	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	72 NFs	0	0	5,875,027	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	560 NFs, HHs, & R	3,462,953	0	5,875,027	5,442	17
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	359 NFs	721,157	0	5,875,027	1,306	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	5,875,027	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,591,078		5,875,027	44,936	22
23	32	Directly Assigned Interest	Not Allocated		16,243,764			40,265	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			34,016,444				24
25	TOTALS				\$ 174,800,957	\$ 39,240,058		\$ 258,171	25

Facility Name & ID Number

Heartland of Macomb

# 0049585

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Conv. Sub. Debentures		X				\$ 581,402	\$ 520,286		0.0774	\$ 40,265	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Home Office Pooled Interest Expense										44,936	6								
7	Interest Income / Interest Expense										(1,641)	7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 581,402	\$ 520,286			\$ 83,560	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 581,402	\$ 520,286			\$ 83,560	15								

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 Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0049585

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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-300-953-00</u>	<u>See Attached</u>	\$ <u>58,678.76</u>	\$ <u>58,678.76</u>
2. <u>11-300-961-00</u>	<u>See Attached</u>	\$ <u>1,223.48</u>	\$ <u>1,223.48</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>59,902.24</u></u>	\$ <u><u>59,902.24</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 Macomb

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,692 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant 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:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Facility (1983, \$57,104), Facility (2003, \$49,141), and TOTALS (\$106,245).

Facility Name & ID Number Heartland of Macomb

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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	58		1983	\$ 824,586	\$ 28,317		\$ 28,317	\$	\$ 1,236,299
5	6		2001	404,817					
6	Audit adj 7/1/03(#1)		2001	(55,875)					
7	16		2003	726,962					
8	Audit adj 7/1/06 (#17)		2003	56,765					
<b>Improvement Type**</b>									
9	Building Improvements (Current Year Depreciation)				105,127		105,127		2,118,675
10	Land Improvements		1983	19,035					
11	Land Improvements - Audit Adj 7/1/03 (#7) - Chg Yr		1983	300					
12	Building Improvements		1984	15,076					
13	Building Improvements		1985	20,813					
14	Building Improvements		1986	42,783					
15	Land Improvements		1986	3,741					
16	Adjust HGCC Purchase		1986	(60,000)					
17	Audit Adj 7/1/03 (#2) - Pg 12, Line 16		1986	60,000					
18	Building Improvements		1987	70,097					
19	Interior Renovation		1987	490					
20	Audit Adj 7/1/03 (#8) - Pg 12, Line 19		1987	(490)					
21	Building Improvements		1988	2,068					
22	Water Heater		1988	732					
23	Audit Adj 7/1/03 (#3) - Pg 12 Line 22		1988	(732)					
24	Repair Valve		1988	1,336					
25	Audit Adj 7/1/03 (#4) - Pg 12 Line 24		1988	(1,336)					
26	Light Fix-Over Bed		1988	3,770					
27	Audit Adj 7/1/03 (#5) - Pg 12 Line 26		1988	(3,770)					
28	Land Improvements		1989	1,614					
29	Building Improvements		1989	25,315					
30	Storage Shed		1990	4,980					
31	Audit Adj 7/1/03 (#6) - Pg 12 Line 30		1990	(4,980)					
32	Land Improvements		1990	950					
33	Building Improvements		1990	11,382					
34	Building (Bldg)		1990	3,186					
35	Audit Adj 7/1/03 (#9) - Pg 12 Line 34		1990	(3,186)					
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

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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	Building Improvements	1991	\$ 5,547	\$		\$	\$	\$	37
38	Building Improvements	1992	10,800						38
39	Land Improvements	1993	23,517						39
40	Building Improvements	1993	13,585						40
41	Building Improvements	1994	51,433						41
42	Land Improvements	1995	4,302						42
43	Building Improvements	1995	121,882						43
44	SMOKE DAMPER	1996	853						44
45	WALLCOVERING	1996	358						45
46	TILE	1996	5,333						46
47	PLUMBING FOR BEAUTY SHOP	1996	3,735						47
48	CABINETS IN PERSONAL CARE	1996	2,450						48
49	ELECTRICAL WIRING FOR PERSONAL	1996	1,740						49
50	TILE FLOOR	1996	824						50
51	ADDITIONAL COST TILE FLOOR	1996	189						51
52	PAINT	1996	1,025						52
53	ADDITIONAL COST A/C (DUCTWORK)	1996	262						53
54	CARPET	1996	846						54
55	COUNTERTOP	1996	894						55
56	PAINTING	1996	1,172						56
57	ADDITIONAL COST FOR SHOWER RENOVATION	1996	278						57
58	HVAC	1996	600						58
59	WALLCOVERING	1996	2,112						59
60	FLOORING	1996	514						60
61	ADDITIONAL WALLCOVERING	1996	6						61
62	WALLCOVERING	1996	382						62
63	CONCRETE	1996	8,812						63
64	PAVING	1996	7,710						64
65	PAVING	1996	13,835						65
66	RENOVATION CHARGES (DUMPSTER)	1996	210						66
67	PAVING-AUDIT ADJ 7/1/03 (#10) - CHG YR	1996	2,652						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,458,287	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	70

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

Facility Name &amp; ID Number Heartland of Macomb

# 0049585

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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,458,287	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	ANGLE BRACKETS FOR HANDRAIL	1997	700						2
3	WALLCOVERING	1997	599						3
4	HANDRAIL	1997	10,069						4
5	PAINTING & WALLCOVERING	1997	15,003						5
6	PAINTING	1997	2,500						6
7	ADDITIONAL COST FOR HANDRAIL	1997	1,480						7
8	COVE BASE	1997	671						8
9	WALL PROTECTION	1997	2,192						9
10	PAINTING & WALLCOVERING	1997	18,964						10
11	(2) NURSES STATION SYSTEMS	1997	11,176						11
12	WALLCOVERING	1997	24						12
13	ELECTRICAL WIRING. OUTLETS & T	1997	3,420						13
14	PAINTING, WALLCOVERING & COVE	1997	19,206						14
15	ADDLT COST FOR A/C	1997	105						15
16	NURSES STATION SYSTEM	1997	4,625						16
17	RENOVATE SHOWER ROOM	1997	939						17
18	A/C HEAT	1997	15,762						18
19	ROOF	1997	3,444						19
20	RENOVATE CENTRAL BATH	1997	2,475						20
21	PLUMBING IN KITCHEN	1997	1,102						21
22	ADDL'T COST FOR A/C	1997	105						22
23	VINYL WALL COVERING FROM INVENTORY	1997	2,425						23
24	HVAC	1997	682						24
25	ADDL'T COST FOR GENERATOR	1997	2,233						25
26	NURSES STATION SYSTEM	1997	1,600						26
27	CABINETS FOR BKKPG & MED RECOR	1997	5,432						27
28	HVAC (ADDL'T COST)	1997	880						28
29	ADDL'T RENOVATION COST	1997	28						29
30	REMODEL BOOKKEEPING OFFICE	1997	150						30
31	ADDL'T GENERATOR COST	1997	120						31
32	CARPET	1997	737						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,587,135	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

Facility Name &amp; ID Number Heartland of Macomb

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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>		\$ 2,587,135	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	DRYWALL	1997	2,750						2
3	PERIMETER ALARM SYSTEM	1997	5,972						3
4	WALLCOVERING	1997	651						4
5	SIDEWALKS	1997	5,875						5
6	Ceiling Tile For Nurses Station	1998	1,446						6
7	Additional Cost for Tile Floor	1998	291						7
8	Wallcovering	1998	414						8
9	Misc Labor & Materials for Gutters	1998	215						9
10	Excavation of Ditch & Storm Sewers	1998	975						10
11	ADDL'T COST FOR PERIMETER ALARM	1998	4,620						11
12	ELECTRICAL WIRING	1998	665						12
13	ADDL'T COST ON FLOORING	1998	16						13
14	ADDL'T COST FOR COUNTERTOPS	1998	604						14
15	TILE FLOOR	1998	704						15
16	CUMMINS/ONAN GENERATOR	1998	24,882						16
17	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	320						17
18	FIRE ALARM CONTROL PANEL	1998	7,925						18
19	A/C HEAT ROOF	1998	672						19
20	GENERATOR	1998	303						20
21	FIRE ALARM SYSTEM	1998	17,066						21
22	GENERATOR	1998	25,364						22
23	HVAC RENOVATION	1998	646						23
24	Audit Adj 7/1/03 (#11) - Pg 12C, Line 23	1998	(646)						24
25	HVAC	1998	283,462						25
26	Audit Adj 7/1/03 (#12) - Pg 12C, Line 25	1998	(5,103)						26
27	SIMPLEX FIRE ALARM SYSTEM	1998	16,846						27
28	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	4,645						28
29	PAINTING & WALLCOVERING	1999	3,457						29
30	DUCTWORK	1999	467						30
31	RE-KEY FACILITY	1999	779						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,993,418	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

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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 12C, Carried Forward</b>		\$ 2,993,418	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	OVERHEAD FROM CONSTRUCTION	1999	4,880						2
3	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 2	1999	(4,880)						3
4	OVERHEAD FROM CONSTRUCTION	1999	27,042						4
5	AUDIT ADJ 7/1/03 (#13) - PG12D, LINE 4	1999	(27,042)						5
6	PAINTING	1999	1,245						6
7	EXIT FIXTURES	1999	2,074						7
8	ARMSTRONG FLOORING	1999	443						8
9	SPRINKLER UPGRADE	1999	14,500						9
10	LOCKING DOOR HARDWARE	1999	2,516						10
11	SPRINKLER UPGRADE	1999	14,500						11
12	DOOR LOCKS	1999	1,434						12
13	PLUMBING IN RESTROOMS	1999	1,330						13
14	SPRINKLER UPGRADE	1999	26,084						14
15	EXIT LIGHT	1999	2,074						15
16	FLOW SWITCH FOR SPRINKLER SYST	1999	342						16
17	QUARRY TILE	1999	9,916						17
18	SPRINKLER UPGRADE	1999	5,798						18
19	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 18	1999	(2,900)						19
20	SMOKE DOORS	1999	1,184						20
21	HVAC	1999	1,557						21
22	VOLUME DAMPERS FOR AIR SUPPLY DUCT	1999	2,445						22
23	DOORS AND DOOR OPENERS	1999	3,500						23
24	DOORS AND FRAMES	1999	11,283						24
25	COMPRESSOR FOR AIR CONDITIONING	1999	3,705						25
26	SECURE CARE SYSTEM	1999	15,373						26
27	DOORS	1999	2,750						27
28	DOOR	1999	200						28
29	EXTERIOR DOORS	1999	10,170						29
30	RETAINAGE - FIRE ALARM SYSTEM	1999	2,146						30
31	AUDIT ADJ 7/1/03 (#14) - PG12D, LINE 30	1999	(2,146)						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,124,941	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

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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>		\$ 3,124,941	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	DOOR ALARM	1999	1,475						2
3	SIDEWALKS	1999	9,020						3
4	SMOKING SHELTER	1999	4,950						4
5	PAVING	1999	4,950						5
6	WALLCOVERING	2000	61						6
7	UPGRADE FIRE ALARM SYST	2000	1,121						7
8	CABINETS FOR BUSINESS OFFICE	2000	2,821						8
9	ELECTRICAL FOR BUS OFFICE	2000	375						9
10	ALARM SYSTEM REPAIRS	2000	808						10
11	CONSTRUCTION & DESIGN OVERHEAD & INTEREST	2000	10,258						11
12	AUDIT ADJ 7/1/03 (#15) - PG12E, LINE 11	2000	(10,258)						12
13	HVAC	2000	18,151						13
14	HVAC CONSULTANT	2000	1,080						14
15	CARPET	2000	820						15
16	ADDL'T COST COUNTER TOPS	2000	313						16
17	CABINETS	2000	2,391						17
18	CARPET	2000	1,931						18
19	THERMO STAT	2000	1,594						19
20	FRT ON CARPET	2000	72						20
21	SOIL UTILITY RENOVATION	2000	3,240						21
22	SOIL UTILITY RENOVATION	2000	360						22
23	CABINETS/COUNTERTOPS	2000	266						23
24	KITCHEN HVAC	2000	2,017						24
25	SOIL UTILITY RENOVATION	2000	2,640						25
26	DUMPSTER ENCLOSURE	2001	2,457						26
27	WALLCOVERINGS	2001	121						27
28	ADDITIONAL COST PAINTING & VWC	2001	1,238						28
29	PAINTING & VWC	2001	138						29
30	CUSTOM CABINETS	2001	5,289						30
31	INSTALL CARPET	2001	641						31
32	(42) WINDOWS & INSTALLATION	2001	22,328						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,217,609	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

Facility Name &amp; ID Number Heartland of Macomb

# 0049585

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 12E, Carried Forward</b>		\$ 3,217,609	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	ADDITIONAL COST - (42) WINDOWS & INST	2001	2,481						2
3	PAINTING	2001	2,880						3
4	PAINTING	2001	320						4
5	General Constr. - Plumbing	2002	1,236						5
6	Interior Renov. - Wallcoverings	2002	822						6
7	AUDIT ADJ 7/1/03 (#16) - PG12F, LINE 6	2002	(822)						7
8	Interior Renov. - Wallcoverings	2002	44,760						8
9	Interior Renov. - Plumbing	2002	1,394						9
10	Building Addition - Wallcovering	2002	4,077						10
11	Border	2002	154						11
12	Additional Cost - Wallcovering	2002	196						12
13	Additional Cost - Wallcovering	2002	481						13
14	HVAC Electrical & Plumbing	2002	33,930						14
15	HVAC Electrical & Plumbing	2002	3,770						15
16	VWC	2002	496						16
17	Building Addition - Landscaping	2002	1,190						17
18	Building Addition - Landscaping	2002	6,442						18
19	Flooring and VWC	2002	4,823						19
20	Carpeting, Painting and Wallcovering	2003	12,897						20
21	7/1/06 Capital Rate Adj #1	2003	(12,897)						21
22	Developers Costs - Overhead	2003	211,116						22
23	7/1/06 Capital Rate Adj #2	2003	(211,116)						23
24	Architect & Engineering Fees	2003	91,070						24
25	Reproduc, Permit & Plan Fees	2003	15,980						25
26	7/1/06 Capital Rate Adj #3	2003	(5,165)						26
27	7/1/06 Capital Rate Adj #4	2003	(10,815)						27
28	Developers Costs - Interest	2003	16,397						28
29	7/1/06 Capital Rate Adj #5	2003	(16,397)						29
30	Millwork & Electric Service	2003	17,781						30
31	7/1/06 Capital Rate Adj #6	2003	(4,641)						31
32	7/1/06 Capital Rate Adj #7	2003	(13,140)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,417,309	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

Facility Name &amp; ID Number Heartland of Macomb

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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 12F, Carried Forward</b>		\$ 3,417,309	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	Developers Costs - Overhead	2003	3,196						2
3	7/1/06 Capital Rate Adj #8	2003	(3,196)						3
4	Developers Costs - Interest	2003	276						4
5	7/1/06 Capital Rate Adj #9	2003	(276)						5
6	<u>Carpeting, Painting and Wallcovering</u>	2003	47,947						6
7	<u>Soil &amp; Concrete Testing</u>	2003	3,480						7
8	<u>Water &amp; Sewer Fees</u>	2003	120						8
9	7/1/06 Capital Rate Adj #10	2003	(120)						9
10	<u>Site Work General Contractor</u>	2003	32,561						10
11	7/1/06 Capital Rate Adj #11	2003	(32,561)						11
12	<u>Retro Cost Adjustment</u>	2003	45,504						12
13	7/1/06 Capital Rate Adj #12	2003	(45,504)						13
14	<u>Window Treatments</u>	2003	8,850						14
15	<u>Soil and Concrete Testing (Addtl Costs)</u>	2003	2,110						15
16	7/1/06 Capital Rate Adj #15	2003	(2,110)						16
17	<u>Engineering Fees</u>	2003	9,194						17
18	7/1/06 Capital Rate Adj #16	2003	(9,194)						18
19	<u>Double Egress Door</u>	2004	5,905						19
20	<u>Construction Drawings &amp; Specs</u>	2004	5,998						20
21	<u>Carpetry, Case Work, Painting</u>	2004	37,880						21
22	<u>Retainage for Addition</u>	2005	1,533						22
23	<u>Flooring, Corner Guards</u>	2005	14,903						23
24	7/1/06 Capital Rate Adj #13	2005	(1,455)						24
25	7/1/06 Capital Rate Adj #14	2005	(55)						25
26	<u>Materials to Complete Addition Project</u>	2005	24,280						26
27	<u>Physical Therapy Addn - LI - Soil Testing</u>	2006	3,773						27
28	<u>Physical Therapy Addn - LI - Landscaping</u>	2006	24,893						28
29	<u>Physical Therapy Addn - LI - Permit Fees</u>	2006	5,423						29
30	<u>Physical Therapy Addn - BI - Genl Contracting</u>	2006	428,270						30
31	<u>Physical Therapy Addn - BI - Carpeting</u>	2006	6,948						31
32	<u>Physical Therapy Addn - BI - Electrical</u>	2006	288						32
33	<u>Physical Therapy Addn - BI - Arch &amp; Eng</u>	2006	51,475						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,087,645	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

Facility Name &amp; ID Number Heartland of Macomb

# 0049585

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 12G, Carried Forward</b>		\$ 4,087,645	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	Physical Therapy Addn - BI - Genl A/H	2006	17,950						2
3	Corr & Main Dining Room - BI - Genl O/H	2006	7,409						3
4	Corr & Main Dining Room - BI - Carpentry	2006	26,688						4
5	Corr & Main Dining Room - BI - Wallcovering	2006	36,561						5
6	HR Office, BB Shop Renovation - BI - Carpet, Wallcovering	2007	6,145						6
7	Fire Safety Caulking	2007	24,060						7
8	Siding and Soffits on Gar	2007	5,100						8
9	Fire Walls and Caulking	2007	24,060						9
10	Cabinets in Beauty Shop	2007	2,982						10
11	<b>FIRE WALLS AND CHALKING</b>	2007	(24,060)						11
12	<b>RENOVATE BREAKROOM - PLUMBING</b>	2008	1,174						12
13	<b>RENOVATE BREAKROOM - CABINETRY</b>	2008	2,321						13
14	<b>RENOVATE BREAKROOM - CEILING</b>	2008	853						14
15	<b>RENOVATE BREAKROOM - PAINTING</b>	2008	704						15
16	<b>RENOVATE BREAKROOM - VINYL TILE FLOORING (VCT)</b>	2008	1,323						16
17	<b>PAINTING CLOSETS</b>	2008	9,850						17
18	<b>ADJ PAINTING CLOSETS</b>	2008	4,174						18
19	Water Heater	2009	16,031						19
20	Water Heater	2009	1,781						20
21	BI 010345 plumbing for asset 10342-dishwasher	2010	19,574						21
22									22
23	10354 Water Lines	2010	8,600						23
24	10355 roof duct	2011	14,367						24
25	10356 Add'l cost roof duct	2011	8,499						25
26	10371 HEAT EXCHANGER	2011	3,835						26
27	10372 Add'l cost roof duct	2011	2,520						27
28	10374 VWC, BASE, & CHAIR RAILS	2011	5,550						28
29	10375 VWC & ORDER, PAINT	2011	5,277						29
30	10397 STORAGE SHED	2012	4,500						30
31									31
32	10403 ICE MACH IN MAIN DINING ROOM	2013	8,600						32
33	10404 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,336,048	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	34

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

Facility Name &amp; ID Number Heartland of Macomb

# 0049585

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 12H, Carried Forward</b>		\$ 4,336,048	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	1
2	10405 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						2
3	10409 SEWER LINE REPLACEMENT	2013	123,120						3
4	10412 0513 Roof Replacement-Main Bldg	2013	195,307						4
5	10414 REPLACE SMOKE DOORS BY ACTIVITIES	2013	5,250						5
6	10415 REP WALK/EMER EGRESS @ SIDE OF BLDG	2013	1,975						6
7									7
8	10421 80 GAL HOT WATER HEATER replaced	2014	16,110						8
9	10429 PAVING-asphalt patching	2014	12,004						9
10									10
11	10430 Boiler Heat Exchanger & Burner replaced	2015	20,205						11
12	10435 Breaker Panel, 100 amp, in boiler room	2015	8,550						12
13	10439 Parking Lot Striping & Sealing	2015	10,790						13
14									14
15	Replaced power supply & interface for fire alarm sys	2016	6,084						15
16	Installed Mixing Valve	2016	2,875						16
17	Install Door & frame - Rear Exit Door	2016	5,000						17
18	Install Door & Frame - Exterior Door by DON office	2016	5,300						18
19	Install Door & Frame - Maintenance Exterior door	2016	5,248						19
20	Install water heater	2016	18,250						20
21	Replace concrete ramp-side of building 30' x 7'	2016	4,630						21
22									22
23	Ceramic tile installation in 400 shower room repair	2017	2,950						23
24	Install down LED light fixture on pole-exterior	2017	4,002						24
25	Install double wall flue pipe in mech room to water heaters	2017	8,545						25
26	Install motor & pump assembly for heating system	2017	3,700						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,801,193	\$ 133,444		\$ 133,444	\$	\$ 3,354,974	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	\$ 1,494,720	\$ 32,676	\$ 32,676	\$		\$ 1,408,731	71
72	Current Year Purchases	15,195						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			6,748	6,748			74
75	TOTALS	\$ 1,509,915	\$ 32,676	\$ 39,424	\$ 6,748		\$ 1,408,731	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)	\$ 6,417,353	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,120	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 172,868	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,748	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,763,705	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 Macomb

# 0049585

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: \$ 35,016 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>2018 T-150 transit van</u>	\$ _____	\$ <u>6,938</u>	17
18	<u>Patient Transportation</u>	<u>2007 Ford E-350 Champion Crusader 8/2</u>		<u>5,349</u>	18
19				<u>above figure includes</u>	19
20				<u>gas &amp; maintenance</u>	20
21	<b>TOTAL</b>		\$ _____	\$ <u>12,287</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)	
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	10a	231 hrs	\$ 10,549	1,751	\$ 125,881	\$ 144	1,982	\$ 136,574	1
2	Licensed Speech and Language Development Therapist	10a	1790 hrs	81,677			2,221	1,790	83,898	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1848 hrs	84,313			7,549	1,848	91,862	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				154,079		154,079	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			18	1,293		18	1,293	12
13	Other (specify): <u>X-Ray &amp; Lab   IV</u>	43, 3 & 2				12,210	12,139		24,349	13
14	<b>TOTAL</b>			\$ 176,539	1,769	\$ 139,384	\$ 176,132	5,638	\$ 492,055	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	\$ 2,189	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>193,728</u> )	822,189		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,346		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>	\$ 829,724	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	106,245		13
14	Buildings, at Historical Cost	4,801,192		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,509,915		16
17	Accumulated Depreciation (book methods)	(4,763,705)		17
18	Deferred Charges	89,988		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>OMIT</u> )	38,630		22
23	Other(specify): <u>CIP</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,782,265	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,611,989	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 130,528	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	262,410		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,902		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accounts Payable</u>	76,957		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 529,797	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	520,286		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>	\$ 520,286	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,050,083	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,561,906	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,611,989	\$	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>2,155,266</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>2,155,266</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>126,130</b>	<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>	\$ <b>126,130</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>(719,490)</b>	<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>	\$ <b>(719,490)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,561,906</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	\$ 6,144,530	1
2	Discounts and Allowances for all Levels	(2,641,726)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,502,804	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,270,232	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,270,232	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	228	12
13	Barber and Beauty Care	4,962	13
14	Non-Patient Meals	9,884	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	308,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	86,203	19
20	Radiology and X-Ray	18,971	20
21	Other Medical Services	36,047	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 464,541	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	150	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 150	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Discounts</u>	588	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 588	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,238,315	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	775,159	31
32	Health Care	2,589,395	32
33	General Administration	1,486,309	33
<b>B. Capital Expense</b>			
34	Ownership	896,448	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	208,039	35
36	Provider Participation Fee	156,835	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,112,185	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	126,130	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 126,130	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,983,159	44
45	Private Pay - Net Inpatient Revenue	616,279	45
46	Medicare - Net Inpatient Revenue	631,472	46
47	Other-(specify) <u>Hospice</u>	91,977	47
48	Other-(specify) <u>Insurance</u>	179,917	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,502,804	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 Macomb

# 0049585

Report Period Beginning:

01/01/17

Ending:

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	2,025	2,224	\$ 87,072	\$ 39.15	1
2	Assistant Director of Nursing	2,026	2,225	64,197	28.85	2
3	Registered Nurses	20,369	22,374	546,251	24.41	3
4	Licensed Practical Nurses	10,688	11,740	225,239	19.19	4
5	CNAs & Orderlies	48,502	53,277	613,969	11.52	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	5,923	6,498	296,510	45.63	7
8	Rehab/Therapy Aides	9,011	9,886	281,616	28.49	8
9	Activity Director	3,662	4,025	55,386	13.76	9
10	Activity Assistants					10
11	Social Service Workers	3,657	4,017	97,063	24.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,900	17,475	209,869	12.01	15
16	Dishwashers					16
17	Maintenance Workers	1,973	2,168	43,166	19.91	17
18	Housekeepers	9,105	10,008	112,046	11.20	18
19	Laundry	1,952	2,145	20,989	9.79	19
20	Administrator	2,080	2,080	105,605	50.77	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,695	12,937	228,793	17.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,842	2,023	29,651	14.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	2,568	2,819	25,074	8.89	33
34	TOTAL (lines 1 - 33)	152,978	167,921	\$ 3,042,496 *	\$ 18.12	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 8,212	9, 3	36
37	Medical Records Consultant	Monthly 2,080	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,292		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Athena Brooks</u>	<u>Administrator</u>	<u>0</u>	\$ <u>105,605</u>	<u>Workers' Compensation Insurance</u>	\$ <u>25,256</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>	<u>38,680</u>	<u>Advertising: Employee Recruitment</u>	<u>24,214</u>	
				<u>FICA Taxes</u>	<u>213,302</u>	<u>Health Care Worker Background Check</u>	<u>6,903</u>	
				<u>Employee Health Insurance</u>	<u>150,565</u>	<u>(Indicate # of checks performed <u>319</u>)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>184</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues &amp; Subscriptions</u>	<u>5,516</u>	
				<u>Disability Payments</u>		<u>Association Dues</u>	<u>5,016</u>	
				<u>401K</u>	<u>8,899</u>	<u>Advertising</u>	<u>32,921</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>105,605</u></b>	<u>Appreciation, Oth Benefits &amp; Mktg Adj</u>	<u>12,572</u>	<u>Other Licenses and Permits</u>	<u>1,297</u>	
<b>(List each licensed administrator separately.)</b>				<u>Tuition Program</u>		<u>Less: Non-Allowable Association Dues</u>	<u>(1,429)</u>	
<b>B. Administrative - Other</b>				<u>Smsp Match</u>	<u>51</u>	<u>Less: Public Relations Expense</u>	( _____ )	
Description			Amount	<u>Employee Uniforms</u>	<u>4,566</u>	<u>Non-allowable advertising</u>	<u>(32,921)</u>	
<u>Various Home Office Services - See Page 8 for breakdown</u>			\$ <u>258,171</u>	<u>Home Office Allocation</u>	<u>20,358</u>	<u>Yellow page advertising</u>	( _____ )	
				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ <u>474,249</u></b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ <u>43,357</u></b>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>258,171</u></b>	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>(Attach a copy of any management service agreement)</b>				Description	Line #	Amount	Description	Amount
<b>C. Professional Services</b>							<u>Out-of-State Travel</u>	\$ _____
Vendor/Payee	Type		Amount					
<u>Various</u>	<u>Legal Fees</u>		\$ <u>56,746</u>				<u>In-State Travel</u>	<u>9,103</u>
<u>Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.</u>							<u>Includes travel expense to the Home Office in Toledo, OH for regional meetings</u>	
							<u>Seminar Expense</u>	
<u>Various</u>	<u>Collections</u>		<u>6,762</u>					
<u>AR Collection Costs were adjusted off via Page 5A, Lines 6 &amp; 7, therefore, no detail schedule is attached.</u>							<u>Entertainment Expense</u>	( _____ )
							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	<b>\$ <u>9,103</u></b>
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>63,508</u></b>	<b>TOTAL</b>		<b>\$ _____</b>		
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Heartland of Macomb

# 0049585

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 \$2413 & AHCA \$1174
- (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. \$ 29,929 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. \$ 156,835  
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. \$ 9,884
- (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