

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0049452</u></p> <p>Facility Name: <u>Heartland of Henry IL, LLC</u></p> <p>Address: <u>1650 Indian Town Road - PO Box 215</u> <u>Henry</u> <u>61537</u> Number City Zip Code</p> <p>County: <u>Marshall</u></p> <p>Telephone Number: <u>(309) 364-3905</u> Fax # <u>(309) 364-3119</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/10/1988</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>A. Dean Shinman</u> Telephone Number: <u>(419) 254-7841</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/18</u> to <u>12/31/18</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Heartland of Henry IL, LLC

0049452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	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	7,749	9,221	5,863	22,833	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,749	9,221	5,863	22,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.55%

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 / /

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/25/18 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 3,633

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 Henry IL, LLC # 0049452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	228,926	13,712	10,443	253,081		253,081		253,081		1
2	Food Purchase		158,227		158,227		158,227	(3,291)	154,936		2
3	Housekeeping	79,340	11,301	1,045	91,686		91,686		91,686		3
4	Laundry	43,478	12,410	789	56,677		56,677		56,677		4
5	Heat and Other Utilities			116,152	116,152	1,215	117,367		117,367		5
6	Maintenance	89,469	24,854	69,648	183,971		183,971		183,971		6
7	Other (specify):* Sanitation & Waste			5,126	5,126		5,126		5,126		7
8	TOTAL General Services	441,213	220,504	203,203	864,920	1,215	866,135	(3,291)	862,844		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,750,408	90,134	39,194	1,879,736	28	1,879,764		1,879,764		10
10a	Therapy	578,617	3,945	16,137	598,699		598,699		598,699		10a
11	Activities	86,729	1,638	1,755	90,122		90,122	(100)	90,022		11
12	Social Services	92,373		1,895	94,268		94,268		94,268		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,508,127	95,717	61,981	2,665,825	28	2,665,853	(100)	2,665,753		16
	C. General Administration										
17	Administrative	98,189		246,630	344,819	(86,570)	258,249		258,249		17
18	Directors Fees										18
19	Professional Services			9,700	9,700	(140)	9,560	(9,560)			19
20	Dues, Fees, Subscriptions & Promotions			59,823	59,823		59,823	(36,422)	23,401		20
21	Clerical & General Office Expenses	181,762	36,710	168,213	386,685	140	386,825	(113,427)	273,398		21
22	Employee Benefits & Payroll Taxes			580,955	580,955	22,513	603,468		603,468		22
23	Inservice Training & Education			5,525	5,525		5,525		5,525		23
24	Travel and Seminar			5,433	5,433		5,433		5,433		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			17,258	17,258		17,258		17,258		26
27	Other (specify):*							(713)	(713)		27
28	TOTAL General Administration	279,951	36,710	1,093,537	1,410,198	(64,057)	1,346,141	(160,122)	1,186,019		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,229,291	352,931	1,358,721	4,940,943	(62,814)	4,878,129	(163,513)	4,714,616		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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
	D. Ownership										
30	Depreciation			174,120	174,120	7,462	181,582		181,582		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			701,743	701,743	55,352	757,095	(709,736)	47,359		32
33	Real Estate Taxes			111,538	111,538		111,538		111,538		33
34	Rent-Facility & Grounds			199,903	199,903		199,903	(199,903)			34
35	Rent-Equipment & Vehicles			21,742	21,742		21,742		21,742		35
36	Other (specify):*										36
37	TOTAL Ownership			1,209,046	1,209,046	62,814	1,271,860	(909,639)	362,221		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		104,472		104,472		104,472		104,472		39
40	Barber and Beauty Shops			14,538	14,538		14,538		14,538		40
41	Coffee and Gift Shops	30,820			30,820		30,820		30,820		41
42	Provider Participation Fee			168,355	168,355		168,355		168,355		42
43	Other (specify):* IV X-Ray & Lab		20,268	47,328	67,596		67,596		67,596		43
44	TOTAL Special Cost Centers	30,820	124,740	230,221	385,781		385,781		385,781		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,260,111	477,671	2,797,988	6,535,770		6,535,770	(1,073,152)	5,462,618		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	(3,291)	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	(1,078)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(316)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(713)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(635)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,181)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(109,400)	21		24
25	Fund Raising, Advertising and Promotional	(36,422)	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	(920,116)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,073,152)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,073,152)		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	Exeptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

Heartland of Henry II, LLC

ID# 0049452

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ (100)	11	1
2	Misc. Income		21	2
3	Vending Income	(543)	21	3
4	Donations Revenue	(1,455)	21	4
5	Accounting/Collection Fees	(8,379)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(709,736)	32	8
9	WT Rent Expense	(199,903)	34	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(920,116)		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
				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	\$ 246,630	HCR Manor Care Services, LLC	0.00%	\$ 246,630	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	3,260,111	Heartland Employment Services, LLC	0.00%	3,260,111		4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,506,741			\$ 3,506,741	\$ *	14

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

Facility Name & ID Number

Heartland of Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

Facility Name & ID Number Heartland of Henry IL, LLC # 0049452 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	6,496,852	\$ 1,215	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	359 NFs	0	0	6,496,852	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	6,496,852	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	560 NFs, HHs, & Re	16,031	10,238	6,496,852	28	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	359 NFs	0	0	6,496,852	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	6,496,852	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	560 NFs, HHs, & Re	59,973,786	32,867,234	6,496,852	104,236	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	359 NFs	16,450,188	6,362,586	6,496,852	32,932	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	72 NFs	2,602,958	0	6,496,852	22,892	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	560 NFs, HHs, & Re	5,900,308	0	6,496,852	10,255	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	359 NFs	6,123,085	0	6,496,852	12,258	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	72 NFs	0	0	6,496,852	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	560 NFs, HHs, & Re	3,462,953	0	6,496,852	6,018	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	359 NFs	721,157	0	6,496,852	1,444	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	72 NFs	0	0	6,496,852	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,591,078		6,496,852	49,692	22
23	32	Directly Assigned Interest	Not Allocated		16,243,764			5,660	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			34,016,444				24
25	TOTALS				\$ 174,800,957	\$ 39,240,058		\$ 246,630	25

Facility Name & ID Number

Heartland of Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	Conv. Sub. Debentures		X			\$ 81,733	\$ 73,141		0.0774	\$ 5,660	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Home Office Pooled Interest Expense									49,692	6							
7	Interest Income / Interest Expense									(7,993)	7							
8											8							
9	TOTAL Facility Related					\$ 81,733	\$ 73,141			\$ 47,359	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$ 81,733	\$ 73,141			\$ 47,359	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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Henry IL, LLC COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0049452

CONTACT PERSON REGARDING THIS REPORT A. Dean Shipman

TELEPHONE (419) 254-7841 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>03-09-326-001</u>	<u>See Attached</u>	\$ <u>118,421.22</u>	\$ <u>118,421.22</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>118,421.22</u></u>	\$ <u><u>118,421.22</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,130 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: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 1988, \$174,000. Row 2: (blank), (blank), (blank). Row 3: TOTALS, \$174,000.

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	93		1988	1988	\$ 1,748,953	\$ 53,363		\$ 53,363	\$	\$ 1,483,221	4
5	1			2005	342,188						5
6	7/1/06 Capital Rate Adjust #5			2005	43,364						6
7											7
8											8
	Improvement Type**										
9		Current Year Depreciation				78,920		78,920		1,943,053	9
10		Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)		1988	(161,519)						10
11		Land/Bldg Improvement (See attached schedule)		1988	487,372						11
12		Door Monitor		1989	2,438						12
13		Land/Bldg. Improvement (See attached schedule)		1990	242						13
14		Land/Bldg. Improvement (See attached schedule)		1991	9,067						14
15		Land/Bldg. Improvement (See attached schedule)		1992	8,628						15
16		Land/Bldg. Improvement (See attached schedule)		1993	19,910						16
17		Move Const Cost From CIP		1993	46,289						17
18		7/1/03 Audit Adj (#1) - Constr Cost		1993	(46,289)						18
19		Land/Bldg. Improvement (See attached schedule)		1994	3,550						19
20		Land/Bldg. Improvement (See attached schedule)		1995	7,068						20
21		(24) DOORS		1996	1,136						21
22		ADDITIONAL COST WALLCOVERING		1996	19						22
23		CARPET		1996	863						23
24		HVAC UPGRADE		1996	2,946						24
25		SEWER LINE CONNECTION		1996	2,398						25
26		SANITARY SEWER		1996	13,155						26
27		SEALCOAT & STRIPE PARKING LOT		1996	3,114						27
28		WALLCOVERING		1997	9,801						28
29		WALLCOVERING		1997	9,019						29
30		PAINTING & WALLCOVERING		1997	13,132						30
31		CROWN MOLDING FOR RENOVATION		1997	198						31
32		CARPET & WALLCOVERING		1997	3,245						32
33		VINYL WALL COVERING FROM INVENTORY		1997	343						33
34		ADDL'T COST FOR HOT WATER		1997	4,822						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	THERMOSTATIC MIXING VALVE	1998	\$ 15,929	\$		\$	\$	\$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,948,456	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	70

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

Facility Name & ID Number Heartland of Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,948,456	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	<u>PAINING</u>	2000	3,000						2
3	<u>PAINING FOR RESIDENTS ROOMS</u>	2000	906						3
4	<u>DOOR HARDWARE</u>	2000	730						4
5	<u>PAINING</u>	2000	3,000						5
6	<u>PAINING</u>	2000	(3,000)						6
7	<u>DRYWALL</u>	2000	7,280						7
8	<u>SMOKE DAMPERS</u>	2000	658						8
9	<u>ADDL'T COST SMOKE DAMPERS</u>	2000	73						9
10	<u>TOTAL DOORS</u>	2000	610						10
11	<u>WALLCOVERING</u>	2000	170						11
12	<u>WALLCOVERING</u>	2000	709						12
13	<u>WALLCOVERING</u>	2000	519						13
14	<u>WALLCOVERING</u>	2000	299						14
15	<u>CEILING</u>	2001	1,225						15
16	<u>CUSTOM WORKSTATION</u>	2001	2,067						16
17	<u>PAINT & WALLCOVERING</u>	2001	1,760						17
18	<u>WALLCOVERING - LOUNGE RENOVATION</u>	2001	557						18
19	<u>WINDOWS</u>	2001	855						19
20	<u>HOT WATER HEATERS</u>	2001	7,900						20
21	<u>DRAPES</u>	2001	2,980						21
22	<u>CARPET</u>	2001	29,586						22
23	<u>ADDTL COSTS FOR CARPET</u>	2001	2,260						23
24	<u>CARPET</u>	2001	500						24
25	<u>WALLCOVERING</u>	2001	516						25
26	<u>WALLCOVERING</u>	2001	90						26
27	<u>CARPENTRY - LOUNGE RENOVATION</u>	2001	6,002						27
28	<u>DRAPES, SHADES, BLINDS - LOUNGE RENOVATION</u>	2001	1,109						28
29	<u>CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION</u>	2001	10,360						29
30	<u>PAINING, WALLCOVERING - LOUNGE RENOVATION</u>	2001	9,691						30
31	<u>PLUMBING - LOUNGE RENOVATION</u>	2001	4,425						31
32	<u>CONCRETE</u>	2001	2,248						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,047,541	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	34

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,047,541	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,268,248	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	34

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,268,248	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,528,482	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	34

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

Facility Name & ID Number Heartland of Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,528,482	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11	CONCRETE UNDER TRANSFER S	2006	2,160						11
12	0607 RES RM RENOV - LIGHT FIXTURES	2007	2,539						12
13	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						13
14	0607 RES RM RENOV - TOILET	2007	6,660						14
15	0607 RES RM RENOV - WALL HEATER	2007	6,000						15
16	0607 RES RM RENOV - PAINTING	2007	3,261						16
17	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						17
18	0607 RES RM RENOV - WALL CABINETS	2007	3,000						18
19	0607 RES RM RENOV - GENL CONDITING	2007	4,033						19
20	2 concrete sidewalks	2008	2,600						20
21	CARPENTRY	2008	500						21
22	0907 EMERGENCY LIGHTING	2008	6,357						22
23	0907 EMERGENCY LIGHTING	2008	38,409						23
24	0907 EMERGENCY LIGHTING	2008	6,454						24
25	0907 EMERGENCY LIGHTING	2008	4,450						25
26	AC CONDENSING UNIT	2008	4,287						26
27	ELECTRICAL FOR TVS	2008	10,260						27
28	SERVICE DOOR ENTRANCEI	2008	5,365						28
29	FIRE RATED SHUTTER	2008	4,806						29
30	DOOR FOR ENTRANCE	2008	5,365						30
31	Entrance Doors	2008	1,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,711,722	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	34

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,711,722	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	BI 022449 0309 FLOORING REPLACEMENT	2010	25,203						2
3	LI 022448 back door concrete pad	2010	4,246						3
4	LI 022459 5' wide sidewalk, therapy	2010	4,038						4
5	LI 022460 Seal & strip pkg lot	2010	4,978						5
6	BI 022463 Radiant Heat Panels	2011	7,450						6
7	BI 022469 135 Sprinkler Heads	2011	10,215						7
8	BI 022481 PT reno-prime/paint ceilings, vwc removal	2011	41,370						8
9	BI 022482 0211 PARKING LOT	2011	83,215						9
10	BI 022484 Wallcovering	2011	19,675						10
11	000000022490 GAS WATER HEATER	2012	5,395						11
12	000000022496 0212 Nurse Call System	2012	1,353						12
13	000000022497 0112 Fire Alarm System	2012	38,093						13
14	000000022498 0112 Fire Alarm System	2012	1,184						14
15	000000022499 ADJ ASSET #22497-fire alarm system	2012	2,898						15
16	000000022500 ADJ ASSET #22497-fire alarm system	2012	6,762						16
17									17
18	22508 Freight for flooring	2013	1,338						18
19	22510 FLOORING - tile for bath/res rm	2013	10,173						19
20	22511 22 RES RM BATH FLOORING	2013	18,357						20
21	22513 22 RESIDENT ROOM FLOORING	2013	6,054						21
22	22517 Water Heater 100, 300 Therav, + Laundry	2013	6,200						22
23	22520 A#22511 RES RM BATH FLOORING	2013	12,188						23
24									24
25	400 Hall Res. Rms - Resilient Flooring	2014	15,520						25
26	400 Hall Res. Rms - Carpeting & Pads	2014	1,399						26
27	400 Hall Res. Rms - Paint & Wall Covering	2014	43,416						27
28	003-14MW 400 Hall Res. Rms - Light Fixtures	2014	11,863						28
29	Pipes for Sprinklers - Wings 100, 200 & 400 (1of3)	2015	3,106						29
30	Pipes for Sprinklers - Wings 100, 200 & 400 (2of3)	2015	8,339						30
31	Water Heater BTR-200 for Kithchen	2015	5,931						31
32	400 Hall Res Rms - Crash Rails, Drywall Repair & Paint	2014	6,165						32
33	400 Hall Drapes/Shades/Blinds	2014	3,791						33
34	TOTAL (lines 1 thru 33)		\$ 4,121,637	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	34

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

Facility Name & ID Number Heartland of Henry IL, LLC# 0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,121,637	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	Generator Panel & Wiring	2015	5,760						2
3	Pipes for Sprinklers - Wings 100, 200 & 400 (3of3)	2015	13,169						3
4	Damper Motor - Kitchen/Mechanical Room	2015	1,027						4
5	HVAC Compressor for unit RT-9702 Model 17358	2015	1,530						5
6	Electrical Wiring for Computers	2015	10,890						6
7	Sprinkler Heads (58) & Dry Pendent Heads (9)	2015	5,022						7
8	Vinyl Fence	2015	2,935						8
9	LED Light Fixtures for parking lot	2015	4,694						9
10									10
11	Replace 4 Centrifugal Downblast Roof Exhaust Fans	2016	4,500						11
12	Water Heater in 400 Hall, AO Smith 80 gallon	2016	3,833						12
13	Repair Drywall then Paint Walls, Floors, & Ceiling in Laundry Room	2016	11,200						13
14	Replace Drywall, Fire Tape/caulk, & Paint Ceilings in Hallways	2016	18,200						14
15									15
16	AHU 10T HVAC System placed above business office	2017	17,000						16
17	Emerg Fire rated Doors & exit devices-Employee ent ext & int, outpt t	2017	23,864						17
18	Secure care exit unit w/keypads in south wing outside exit	2017	9,525						18
19	Metal door 400 hall	2017	5,609						19
20	Hot water heater off dining room	2017	7,260						20
21									21
22	Drywall -200 Hall Large Dining room (2)	2018	9,860						22
23	Ceiling in PT	2018	3,000						23
24	Add'l -Drywall -200 Hall Large Dining room (2)	2018	3,288						24
25	Pass Thru Window -Kitchen	2018	6,500						25
26	Ceiling & Paint - Kitchen	2018	6,500						26
27	Add'l -Ceiling in PT	2018	2,500						27
28	Add'l -Ceiling in PT	2018	3,150						28
29	Ceiling & Paint - Dining Room	2018	6,500						29
30	Add'l -Ceiling & Paint - Dining Room	2018	5,767						30
31	Exit Doors HM - halls 100, 300, & 400 (3)	2018	5,000						31
32	Drywall and paint -Arcardia Lounge	2018	2,950						32
33	part of A# 22694	2018							33
34	TOTAL (lines 1 thru 33)		\$ 4,322,670	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	34

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

Facility Name & ID Number Heartland of Henry IL, LLC

0049452

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,322,670	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	1
2	Duct Insulation in Attic	2018	3,912						2
3	Add'l -Duct Insulation in Attic	2018	3,912						3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,330,494	\$ 132,283		\$ 132,283	\$	\$ 3,426,274	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	\$ 1,998,424	\$ 41,837	\$ 41,837	\$		\$ 1,895,314	71
72	Current Year Purchases	30,077						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			7,462	7,462			74
75	TOTALS	\$ 2,028,501	\$ 41,837	\$ 49,299	\$ 7,462		\$ 1,895,314	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)	\$ 6,532,995	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 174,120	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,582	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,462	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,321,588	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 Henry IL, LLC

0049452

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 15,181 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 Transport</u>	<u>2013 Dodge Grand Caravan</u>	\$ _____	\$ <u>3,856</u>	17
18		<u>2017 T-150 Transit Van</u>		<u>2,705</u>	18
19		<u>(Transferred from Paxton)</u>		<u>above amount includes</u>	19
20				<u>gas & maintenance too</u>	20
21	TOTAL		\$ _____	\$ <u>6,561</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	1749 hrs	\$ 74,476		\$	77	1,749	\$ 74,553	1
2	Licensed Speech and Language Development Therapist	10a	882 hrs	37,544				882	37,544	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	1625 hrs	69,199			3,868	1,625	73,067	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 prescripts				104,472		104,472	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			252	15,739		252	15,739	12
13	Other (specify): <u>X-Ray & Lab IV</u>	43, 2 & 3				47,328	20,268		67,596	13
14	TOTAL			\$ 181,219	252	\$ 63,067	\$ 128,685	4,508	\$ 372,971	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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 250	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (207,289))	397,085		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,844		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 408,179	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	4,330,494		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,028,501		16
17	Accumulated Depreciation (book methods)	(5,321,588)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) OMIT	88,906		22
23	Other(specify): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,300,313	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,708,492	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 97,374	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	351,720		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,421		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	53,351		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 620,866	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	73,141		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	WTRnt Exp Lease Pymt			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 73,141	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 694,007	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,014,485	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,708,492	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,366,439	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,366,439	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(737,914)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (737,914)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	385,960	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 385,960	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,014,485	24 *

* 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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,738,979	1
2	Discounts and Allowances for all Levels	(2,270,750)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,468,229	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,946,383	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,946,383	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,256	12
13	Barber and Beauty Care	19,793	13
14	Non-Patient Meals	3,291	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,500	16
17	Sale of Drugs	239,590	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	77,170	19
20	Radiology and X-Ray	10,822	20
21	Other Medical Services	27,189	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 380,611	23
D. Non-Operating Revenue			
24	Contributions	1,455	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,455	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discount</u>	1,178	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,178	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,797,856	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	864,920	31
32	Health Care	2,665,825	32
33	General Administration	1,410,198	33
B. Capital Expense			
34	Ownership	1,209,046	34
C. Ancillary Expense			
35	Special Cost Centers	217,426	35
36	Provider Participation Fee	168,355	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,535,770	40
41	Income before Income Taxes (line 30 minus line 40)**	(737,914)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (737,914)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,023,325	44
45	Private Pay - Net Inpatient Revenue	1,945,371	45
46	Medicare - Net Inpatient Revenue	317,543	46
47	Other-(specify) <u>Hospice</u>	116,992	47
48	Other-(specify) <u>Insurance</u>	64,998	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,468,229	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 Henry IL, LLC

0049452

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	1,840	2,038	\$ 100,935	\$ 49.53	1
2	Assistant Director of Nursing	3,274	3,627	120,744	33.29	2
3	Registered Nurses	16,315	18,071	507,781	28.10	3
4	Licensed Practical Nurses	12,598	13,955	326,686	23.41	4
5	CNAs & Orderlies	45,283	50,219	662,520	13.19	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	7,297	8,081	344,137	42.59	7
8	Rehab/Therapy Aides	7,139	7,906	234,480	29.66	8
9	Activity Director	6,272	6,952	86,729	12.48	9
10	Activity Assistants					10
11	Social Service Workers	3,756	4,163	92,373	22.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,361	19,247	228,926	11.89	15
16	Dishwashers					16
17	Maintenance Workers	4,165	4,579	89,469	19.54	17
18	Housekeepers	6,792	7,527	79,340	10.54	18
19	Laundry	4,075	4,518	43,478	9.62	19
20	Administrator	2,080	2,080	98,189	47.21	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,085	7,916	181,762	22.96	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	1,453	1,610	31,742	19.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	2,957	3,280	30,820	9.40	33
34	TOTAL (lines 1 - 33)	149,742	165,769	\$ 3,260,111 *	\$ 19.67	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 3,000	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)	\$ 3,000		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 & ID Number Heartland of Henry IL, LLC

0049452

Report Period Beginning: 01/01/18

Ending: 12/31/18

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 \$2,762 & AHCA \$1,380
- (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. \$ 23,232 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. 7/25/18
- (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. \$ 168,355
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. \$ 3,291
- (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