

Facility Name & ID Number Heartland of Paxton

0049494 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	106	Skilled (SNF)	106	38,690	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	106	TOTALS	106	38,690	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	10,221	9,284	7,335	26,840	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,221	9,284	7,335	26,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.37%

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

0 (Do not include bed-hold 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 10/3/1988

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 106 and days of care provided 4,561

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 Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	261,441	20,972	78,730	361,143		361,143		361,143		1
2	Food Purchase		280,200		280,200		280,200	(11,306)	268,894		2
3	Housekeeping	154,722	16,765	22,256	193,743		193,743		193,743		3
4	Laundry	19,536	24,457		43,993		43,993		43,993		4
5	Heat and Other Utilities			144,565	144,565	1,679	146,244		146,244		5
6	Maintenance	52,567	14,252	92,380	159,199		159,199		159,199		6
7	Other (specify):* Med Waste			1,151	1,151		1,151		1,151		7
8	TOTAL General Services	488,266	356,646	339,082	1,183,994	1,679	1,185,673	(11,306)	1,174,367		8
	B. Health Care and Programs										
9	Medical Director			43,824	43,824		43,824		43,824		9
10	Nursing and Medical Records	2,179,719	213,693	82,708	2,476,120	5,636	2,481,756		2,481,756		10
10a	Therapy	703,067	10,468	45,509	759,044		759,044		759,044		10a
11	Activities	62,354	8,240	296	70,890		70,890		70,890		11
12	Social Services	139,204	611	6,335	146,150		146,150		146,150		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,084,344	233,012	178,672	3,496,028	5,636	3,501,664		3,501,664		16
	C. General Administration										
17	Administrative	73,533		376,779	450,312	(144,046)	306,266		306,266		17
18	Directors Fees										18
19	Professional Services			26,343	26,343	(980)	25,363	(25,363)			19
20	Dues, Fees, Subscriptions & Promotions			102,069	102,069		102,069	(35,810)	66,259		20
21	Clerical & General Office Expenses	267,462	51,827	318,250	637,539	980	638,519	(214,467)	424,052		21
22	Employee Benefits & Payroll Taxes			624,647	624,647	25,262	649,909		649,909		22
23	Inservice Training & Education			2,354	2,354		2,354		2,354		23
24	Travel and Seminar			25,598	25,598		25,598		25,598		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,177	49,177		49,177		49,177		26
27	Other (specify):*							(463)	(463)		27
28	TOTAL General Administration	340,995	51,827	1,525,217	1,918,039	(118,784)	1,799,255	(276,103)	1,523,152		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,913,605	641,485	2,042,971	6,598,061	(111,469)	6,486,592	(287,409)	6,199,183		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			296,470	296,470	8,601	305,071		305,071			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			661,372	661,372	102,868	764,240	(664,092)	100,148			32
33	Real Estate Taxes			78,581	78,581		78,581		78,581			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			86,709	86,709		86,709		86,709			35
36	Other (specify):*											36
37	TOTAL Ownership			1,123,132	1,123,132	111,469	1,234,601	(664,092)	570,509			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		240,682		240,682		240,682		240,682			39
40	Barber and Beauty Shops		2,478	11,476	13,954		13,954		13,954			40
41	Coffee and Gift Shops	52,299			52,299		52,299		52,299			41
42	Provider Participation Fee			187,908	187,908		187,908		187,908			42
43	Other (specify):* IV X-ray & lab		40,254	69,472	109,726		109,726		109,726			43
44	TOTAL Special Cost Centers	52,299	283,414	268,856	604,569		604,569		604,569			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,965,904	924,899	3,434,959	8,325,762		8,325,762	(951,501)	7,374,261			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	(11,306)	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	(632)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(480)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(463)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,352)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,388)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(210,514)	21		24
25	Fund Raising, Advertising and Promotional	(35,810)	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 Page 5a	(669,556)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (951,501)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (951,501)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heartland of Paxton

Report Period Beginning: 01/01/15
 Ending: 12/31/15

ID# 0049494

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

1	Activity Income	\$	11	1
2	Misc. Income	(29)	21	2
3	Vending Income	(1,099)	21	3
4	Accounting/Collection Fees	(3,975)	19	4
5	Collection Agency		19	5
6	Loss on Disposal of Fixed Asset		36	6
7	HCP Lease Interest	(664,092)	32	7
8	Donation Revenue	(361)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(669,556)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,306)	0	0	0	0	0	0	0	0	0	0	(11,306)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,306)	0	0	0	0	0	0	0	0	0	0	(11,306)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,363)	0	0	0	0	0	0	0	0	0	0	(25,363)	19
20	Fees, Subscriptions & Promotions	(35,810)	0	0	0	0	0	0	0	0	0	0	(35,810)	20
21	Clerical & General Office Expenses	(214,467)	0	0	0	0	0	0	0	0	0	0	(214,467)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(463)	0	0	0	0	0	0	0	0	0	0	(463)	27
28	TOTAL General Administration	(276,103)	0	0	0	0	0	0	0	0	0	0	(276,103)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(287,409)	0	0	0	0	0	0	0	0	0	0	(287,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15 Ending:

12/31/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(664,092)	0	0	0	0	0	0	0	0	0	0	(664,092)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(664,092)	0	0	0	0	0	0	0	0	0	0	(664,092)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(951,501)	0	0	0	0	0	0	0	0	0	0	(951,501)	45

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 Svc	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See						1
2	V	Page 8						2
3	V							3
4	V	1-44						4
5	V	10a						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		\$ 4,307,241			\$ 4,307,241	\$ *	14

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

Facility Name & ID Number

Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 Decatur IL, LLC	Decatur				2
3			Heartland of Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8								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 Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14								14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

Heartland of Paxton

0049494

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12/31/15

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			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6			Heartland of Champaign IL, LLC	Champaign				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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Paxton

0049494

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 Summitt 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	559 NFs, HHs,	\$ 818,127		8,054,608	\$ 1,679	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			8,054,608	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	85 NFs			8,054,608	0	3
4	10	Nursing - Pooled	Accumulated Cost	559 NFs, HHs, & R	314,713	212,796	8,054,608	646	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,144,378	1,338,476	8,054,608	4,990	5
6	10	Nursing - Direct to West Div SNFs	Accumulated Cost	85 NFs			8,054,608	0	6
7	17	Gen & Admin - Pooled	Accumulated Cost	559 NFs, HHs, & R	60,268,030	28,103,285	8,054,608	123,689	7
8	17	Gen & Admin - Direct to all SNFs	Accumulated Cost	357 NFs	14,494,897	5,630,812	8,054,608	33,728	8
9	17	General & Administrative - Direct to all SNFs	Accumulated Cost	85 NFs	3,257,281		8,054,608	28,268	9
10	22	Employee Benefits - Pooled	Accumulated Cost	559 NFs, HHs, & R	5,205,729		8,054,608	10,684	10
11	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	357 NFs	6,264,775		8,054,608	14,578	11
12	22	Employee Benefits - Direct to West Div SNFs	Accumulated Cost	85 NFs	0		8,054,608	0	12
13	30	Depreciation - Pooled	Accumulated Cost	559 NFs, HHs, & R	3,394,861		8,054,608	6,967	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	357 NFs	702,366		8,054,608	1,634	14
15	30	Depreciation - Direct to West Div SNFs	Accumulated Cost	85 NFs			8,054,608	0	15
16									16
17									17
18									18
19	32	Pooled Interest	Accumulated Cost		28,376,750		8,054,608	58,238	19
20	32	Directly Assigned Interest	Not Allocated		18,868,647			44,630	20
21									21
22	24	H/O costs Allocated to non-SNF & Other Divisions			33,166,797				22
23									23
24									24
25	TOTALS				\$ 177,277,351	\$ 35,285,369		\$ 329,731	25

Facility Name & ID Number

Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Conv. Sub Debentures		X	Various			\$ 618,583	\$ 591,043		0.0755	\$ 44,630						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7	Pooled Interest										58,238						
8	Interest Expense / Interest Income										(2,720)						
9	TOTAL Facility Related						\$ 618,583	\$ 591,043			\$ 100,148						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 618,583	\$ 591,043			\$ 100,148						

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	<u>76,118</u>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>77,350</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,231</u>	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>77,350</u>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>78,581</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>73,011</u>	8	FOR BHF USE ONLY	
	2011	<u>73,162</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$
	2012	<u>73,439</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2013	<u>76,118</u>	11	15	LESS REFUND FROM LINE 6 \$
	2014	<u>77,350</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
Lines 2 & 4: \$38,674.78 for 1st half 2014 + \$38,674.78 for 2nd half 2014.					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Paxton COUNTY Ford
 FACILITY IDPH LICENSE NUMBER 0049494
 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 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-14-08-476-001</u>	<u>See Attached</u>	\$ <u>77,349.56</u>	\$ <u>77,349.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>77,349.56</u></u>	\$ <u><u>77,349.56</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Paxton

0049494 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,285 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).

N/A

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 75,186</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 75,186	3

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	96	1988	1988	\$ 1,323,187	\$ 157,270		\$ 157,270	\$	\$ 2,784,007	4
5	Audit Adj#1- Overhd & Int(year 1998) & Aud Adj #2 Various(year 2001)			1,536,322						5
6			2004	673,649						6
7			2008	649,952						7
8	10		2009	558,648						8
Improvement Type**										
9	Current Year Depreciation				62,791		62,791		1,794,472	9
10	Land/Bldg. Improvement (See attached schedule		1988	279,229						10
11	Additional Attic Insulation		1989	3,500						11
12	Fire Alarm System		1990	294						12
13	Audit Adj (#3) - Fire Alarm System		1990	(294)						13
14	Land/Bldg. Improvement (See attached schedule		1990	8,348						14
15	Land/Bldg. Improvement (See attached schedule		1991	6,404						15
16	Land/Bldg. Improvement (See attached schedule		1992	24,904						16
17	Land/Bldg. Improvement (See attached schedule		1993	12,778						17
18	Land/Bldg. Improvement (See attached schedule		1994	1,010						18
19	Land/Bldg. Improvement (See attached schedule		1995	14,522						19
20	BATHTUB		1996	356						20
21	(7) DOORS		1996	3,896						21
22	WALLCOVERING		1996	1,133						22
23	CARPET & WALLCOVERING		1996	2,199						23
24	CEILING		1997	2,101						24
25	WALLCOVERING		1997	8,139						25
26	WALLCOVERING		1997	22						26
27	CREDIT ON BLD IMP-CNCLD RETAIN		1997	(434)						27
28	WALLCOVERING		1997	13,695						28
29	CARPET		1997	1,081						29
30	WALLCOVERING		1997	1,571						30
31	ENGINEERING AND ARCHITECTURAL FEES		1997	75,055						31
32	Audit Adj (#4) - Various		1997	(22,168)						32
33	(14) PKG AMANA A/C UNITS		1997	9,051						33
34	PAINTING		1997	10,933						34
35	PAINTING & WALLCOVERING		1997	7,933						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 Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	NURSE CALL SYSTEM	1997	\$ 2,561	\$		\$	\$	\$	37
38	VINYL WALL COVERING FROM INVENTORY	1997	293						38
39	VINYL WALL COVERING FROM INVENTORY	1997	187						39
40	VINYL WALL COVERING FROM INVENTORY	1997	814						40
41	CUBICLE CURTAIN TRACK	1997	1,416						41
42	NURSE CALL SYSTEM UPGRADE	1997	2,305						42
43	WALLCOVERING	1997	157						43
44	CROWN MOLDING & CHAIR RAIL	1997	820						44
45	GARAGE WOOD	1997	12,983						45
46	ADDL'T COST FOR NURSE CALL SYSTEM #15	1998	167						46
47	WALLCOVERING	1998	191						47
48	COVE BASE	1998	1,529						48
49	WALLCOVERING	1998	75						49
50	DOOR ALARMS	1998	3,598						50
51	WALLCOVERING	1998	249						51
52	SECURE CARE LOCKS	1998	11,971						52
53	ADDL'T NURSE CALL SYSTEM	1998	1,901						53
54	WALLPAPER FROM CONSTRUCTION	1998	196						54
55	GATE	1998	390						55
56	A/C UNIT	1998	1,925						56
57	HVAC FOR ADDITION	1998	47,008						57
58	AUDIT ADJ (#5) - VARIOUS	1998	(6,158)						58
59	BRASH BARRY GENERAL CONSTRUCTION	1998	23,132						59
60	REMOVE OVERHEAD PAGING	1998	338						60
61	WALLCOVERING	1998	7,678						61
62	CABINERY & COUTNERTOPS	1998	8,240						62
63	CARPENTRY	1998	24,126						63
64	ELECTRICAL WORK	1998	444						64
65	ELECTRICAL WORK	1998	32,894						65
66	LIGHT FIXTURES	1998	1,253						66
67	PLUMBING WORK	1998	711						67
68	LAWNCARE SEEDED CONSTRUCTION AREA	1998	440						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,390,850	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	70

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

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 5,390,850	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	1
2	SPRINKLER SYSTEM	1998	45,812						2
3	FIRE ALARM SYSTEM	1998	3,370						3
4	FENCE	1998	6,507						4
5	PAVING	1998	38,079						5
6	CONSTRUCTION AND DESIGN OVERHEAD COST	1999	114,792						6
7	AUDIT ADJ (#6) - OVERHEAD COST	1999	(114,792)						7
8	DIRECT VENT UNIT HEATER	1999	1,556						8
9	SECURE CARE LOCKING SYSTEM	1999	958						9
10	SEAL & STRIPE PARKING LOT	1999	3,136						10
11	EXTERIOR LIGHTING	1999	20,250						11
12	SINK & FAUCET	2000	596						12
13	NURSES STATION	2000	11,790						13
14	COUNTERTOP	2000	1,200						14
15	VCT	2000	1,140						15
16	WATER HEATER	2000	3,780						16
17	NURSES STATION	2000	475						17
18	PAINTING	2000	11,005						18
19	CUSTOM CABINETS	2000	7,091						19
20	INSTALL CARPET	2001	593						20
21	GAZEBO	2001	4,319						21
22	CARPENTRY-ARCADIA RENOV	2001	16,430						22
23	CARPENTRY-ARCADIA RENOV	2001	13,084						23
24	AUDIT ADJ (#7) - CARPENTRY	2001	(1,469)						24
25	LANDSCAPING-ARCADIA RENOV	2002	21,295						25
26	AUDIT ADJ (#2) - TRANSFER TO BUILDING	2002	(21,295)						26
27	PAINTING	2002	7,175						27
28	PAINTING	2002	825						28
29	DRAPES	2002	130						29
30	FLOORING.VINYL WALL COVERING	2002	8,405						30
31	OUTDOOR LIGHTING	2002	1,560						31
32	DOORS	2002	5,900						32
33	HALLWAY PAINT AND BORDER	2002	1,150						33
34	TOTAL (lines 1 thru 33)		\$ 5,605,697	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	34

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

Facility Name & ID Number Heartland of Paxton

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		\$ 5,605,697	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	1
2	MDS OFFICE-VINYL WALL COVERING	2003	419						2
3	AUDIT ADJ (#9) - VWC	2003	(25)						3
4	MDS OFFICE-PAINTING & VINYL WALL COVERING	2003	945						4
5	MDS OFFICE-RETAINAGE-PAINTING & VWC	2003	105						5
6	MDS OFFICE-ELECTRIC WORK	2003	1,338						6
7	MDS OFFICE-BORDER	2003	66						7
8	AUDIT ADJ (#10) - BORDER	2003	(4)						8
9	CARPET	2003	1,051						9
10	SNF ADDITION-ARCHITECT COSTS	2003	4,612						10
11	OUTLETS IN DINING ROOM	2003	1,280						11
12	TESTING GEOTECHNICAL	2003	3,519						12
13	ENGINEERING, ARCHITECTURAL FEES	2003	156,819						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(63,267)						14
15	RESILIENT FLOORING	2004	17,087						15
16	7/1/06 CAPITAL RATE ADJUST #1	2004	(137)						16
17	SECURITY DOOR	2004	5,354						17
18	WATER,SEWER,UTILITIES FOR ADDITION	2004	44,792						18
19	7/1/06 CAPITAL RATE ADJUST #2	2004	(44,792)						19
20	VINYL WALL COVERING, FLOORING	2004	12,441						20
21	VINYL WALL COVERING, FLOORING (ADJUSTMENT)	2004	(75)						21
22	MILLWORK	2004	2,815						22
23	NEW ROOF	2004	88,184						23
24	SECURITY DOOR	2005	4,932						24
25	CONCRETE WALK & PAD	2006	558						25
26	5 PTAC UNITS	2006	4,136						26
27	CUSTOM WORKSTATIONS	2006	1,806						27
28	DINING,LOBBY,OFFICE-GENL O/H	2007	6,606						28
29	DINING-CARPENTRY	2007	38,528						29
30	ADMISSIONS-CARPENTRY	2007	10,290						30
31	DINING-WALLCOVERING	2007	3,595						31
32	LOBBY-WALLCOVERING	2007	2,288						32
33	ADMINISTRATOR-WALLCOVERING	2007	855						33
34	TOTAL (lines 1 thru 33)		\$ 5,911,817	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	34

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

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 5,911,817	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	1
2	ADMISSIONS-WALLCOVERING	2007	823						2
3	DINING,LOBBY,OFFICE-INTEREST	2007	486						3
4	CEILING	2007	14,580						4
5	CONF RM BIRD LOUNGE	2006	2,228						5
6	PAXTON PT - GEN'L CONTRACTOR	2008	980						6
7	PAXTON PT - LANDSCAPING	2008	11,376						7
8	PAXTON PT - CONCRETE TESTING	2008	1,478						8
9	PAXTON PT -SOIL TESTING	2008	2,175						9
10	PAXTON PT - ARCH & ENGINEER COST	2008	63,523						10
11	PAXTON PT - GENERAL OVERHEAD CAPITAL	2008	236,698						11
12	PAXTON PT - PLAN REVIEWS	2008	6,000						12
13	PAXTON PT - INTEREST ON CONSTRUCTION	2008	37,527						13
14	PAXTON PT - ELECTRICAL	2008	110						14
15	PAXTON PT - CARPETING & PADS	2008	1,770						15
16	PAXTON PT - WALL COVERING	2008	394						16
17									17
18	00000050576 Ren-Gen ovhd capit	2009	33,063						18
19	00000050576 Renovation-interest on const	2009	1,169						19
20	00000050579 Renovation -Carpentry	2009	91,141						20
21	00000050580 Ren-lobby finishes	2009	3,520						21
22	00000050580 Ren-carpeting & pads	2009	12,110						22
23	00000050580 Ren-wallcovering	2009	14,890						23
24	50582 PAX ADD-Architect & Eng Cost	2009	85,342						24
25	50584 PAX ADD-General Overhead Capital	2009	10,719						25
26	50588 PAX ADD-interest on construction	2009	4,129						26
27	50589 PAX ADD-millwork	2009	4,815						27
28	50590 PAX ADD-wall cov, cubicle track & corn guards	2009	9,608						28
29	LI-50583 PAX ADD-Soil & concrete testing	2009	3,936						29
30	LI-50591 PAX ADD-Gen Contractor-sitework	2009	54,829						30
31									31
32	BI 50582 PAXTON ADD-architect & eng cost	2009	1,078						32
33	BI 50614 Flooring	2010	11,415						33
34	TOTAL (lines 1 thru 33)		\$ 6,633,730	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	34

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

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 6,633,730	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	1
2	BI 050625 ceramic flooring, walls s	2011	13,666						2
3	BI 050645 SEALCOAT & STRIPPING OF P	2011	6,738						3
4	BI 050646 HOT WATER HEATER	2011	5,301						4
5	000000050657 SIDEWALK REPLACEMENTS	2012	4,328						5
6	000000050660 CABINETS (DOCTOR'S OFFICE	2012	4,899						6
7	000000050666 WATER HEATER	2012	11,475						7
8									8
9	50670 INSTALL DIN RM FURNACE IN MECH RM	2013	3,625						9
10	50675 WINDOW FIRE SHUTTER	2013	3,356						10
11	50679 INSTALL KITCHEN FIRE WINDOW	2013	300						11
12									12
13	50688 Electrical Breaker Panel	2014	1,645						13
14	50695 wallcovering for therapy room expansion	2014	1,190						14
15	50696 Carpentry for therapy room expansion	2014	43,023						15
16	50697 Architect & Eng cost-therapy room expansion	2014	18,918						16
17	50712 Paving in two areas	2014	19,665						17
18	50714 A#50697 Architech & Engineer cost adj	2014	1,650						18
19									19
20	50717 HVAC change for fire sprinklers	2014	6,732						20
21	50818 ARCHITECT fees for fire spnkls/HVAC	2014	1,341						21
22	50735 TILE FLOOR-res room	2015	1,346						22
23	50736 Paint & WALLCOVERING-reception area	2015	5,000						23
24	50738 Paint & WALLCOVERING-reception area	2015	15,336						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)		\$ 6,803,263	\$ 220,061		\$ 220,061	\$	\$ 4,578,479	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	\$ 2,062,276	\$ 76,409	\$ 76,409	\$		\$ 1,868,467	71
72	Current Year Purchases	43,656						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			8,601	8,601			74
75	TOTALS	\$ 2,105,932	\$ 76,409	\$ 85,010	\$ 8,601		\$ 1,868,467	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)	\$ 8,984,381	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 296,470	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 305,071	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,601	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,446,946	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 Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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:	N/A			\$			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.	_____ /2016	\$ _____
-----	-------------	----------

13.	_____ /2017	\$ _____
-----	-------------	----------

14.	_____ /2018	\$ _____
-----	-------------	----------

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: \$ 76,032

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	Patient Transportation	2009 Ford E-350 Cutaway	\$ 55.00	\$ 10,677	17
18					18
19				above figure includes	19
20				gas & maintenance	20
21	TOTAL		\$ 55.00	\$ 10,677	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?</p> <p><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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	2812	hrs	\$ 110,362	418	\$ 27,870	\$ 254	3,230	\$ 138,486	1
2	Licensed Speech and Language Development Therapist	10a	1732	hrs	67,977			848	1,732	68,825	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4958	hrs	194,595	8	526	9,366	4,966	204,487	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				240,682		240,682	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2						40,254		40,254	12
13	Other (specify): <u>X-ray & Lab</u>	43, 3					69,472			69,472	13
14	TOTAL				\$ 372,934	426	\$ 97,868	\$ 291,404	9,928	\$ 762,206	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.

Facility Name & ID Number Heartland of Paxton# 0049494Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,779	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>358,865</u>)	838,205		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 851,984	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,186		13
14	Buildings, at Historical Cost	6,803,262		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,105,932		16
17	Accumulated Depreciation (book methods)	(6,446,946)		17
18	Deferred Charges	7,712,445		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>OMIT</u>)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,249,879	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,101,863	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,581	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	317,046		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,350		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	107,314		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 586,291	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	591,043		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 591,043	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,177,334	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,924,529	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,101,863	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,022,330	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,022,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,279,353)	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)	\$ (1,279,353)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	1,181,552	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,181,552	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,924,529	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	\$ 7,021,507	1
2	Discounts and Allowances for all Levels	(3,082,726)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,938,781	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,385,707	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,385,707	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	1,562	12
13	Barber and Beauty Care	13,149	13
14	Non-Patient Meals	11,306	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	495,807	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,413	19
20	Radiology and X-Ray	29,077	20
21	Other Medical Services	106,585	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 720,899	23
D. Non-Operating Revenue			
24	Contributions	361	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 361	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discount	661	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 661	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,046,409	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,183,994	31
32	Health Care	3,496,028	32
33	General Administration	1,918,039	33
B. Capital Expense			
34	Ownership	1,123,132	34
C. Ancillary Expense			
35	Special Cost Centers	416,661	35
36	Provider Participation Fee	187,908	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,325,762	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,279,353)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,279,353)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,244,521	44
45	Private Pay - Net Inpatient Revenue	2,076,764	45
46	Medicare - Net Inpatient Revenue	441,035	46
47	Other-(specify) <u>Hospice</u>	24,263	47
48	Other-(specify) <u>Insurance</u>	152,198	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,938,781	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 Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,335	1,442	\$ 52,054	\$ 36.10	1
2	Assistant Director of Nursing	4,379	4,728	136,938	28.96	2
3	Registered Nurses	20,727	22,377	657,022	29.36	3
4	Licensed Practical Nurses	23,467	25,336	566,769	22.37	4
5	CNAs & Orderlies	57,037	61,734	757,795	12.28	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,130	13,088	513,659	39.25	7
8	Rehab/Therapy Aides	5,959	6,430	189,408	29.46	8
9	Activity Director	4,001	4,319	62,354	14.44	9
10	Activity Assistants					10
11	Social Service Workers	6,559	7,078	139,204	19.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,831	21,430	261,441	12.20	15
16	Dishwashers					16
17	Maintenance Workers	2,007	2,169	52,567	24.24	17
18	Housekeepers	12,940	13,985	154,722	11.06	18
19	Laundry	1,917	2,072	19,536	9.43	19
20	Administrator	2,080	2,080	73,533	35.35	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,170	14,146	267,462	18.91	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	610	659	9,141	13.87	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	3,571	3,857	52,299	13.56	33
34	TOTAL (lines 1 - 33)	191,720	206,930	\$ 3,965,904 *	\$ 19.17	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 43,824	9, 3	36
37	Medical Records Consultant	Monthly 2,296	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)	\$ 46,120		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	171 \$ 11,968	10, 3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	171 \$ 11,968		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	
Norman Gross (Jan- Apr)	Purch Serv Administrator	0	\$ 0	Workers' Compensation Insurance	\$ 60,168	IDPH License Fee	\$	
Clarence Boykin (April-Dec)	Administrator	0	73,533	Unemployment Compensation Insurance	58,488	Advertising: Employee Recruitment	40,710	
				FICA Taxes	281,186	Health Care Worker Background Check	2,163	
				Employee Health Insurance	202,656	(Indicate # of checks performed <u>70</u>)		
(Norman Gross's wages of \$47,048 are included in Schedule V, line 17, col. 3)				Employee Meals		Patient Background Checks	472 4,729	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,763	
				Employee Appreciation		Association Dues	6,042	
				401K	5,196	Advertising	33,812	
TOTAL (agree to Schedule V, line 17, col. 1)				Oth Empl Benefits & Marketing Adjustment	7,061	Other Licenses & Permits	(150)	
(List each licensed administrator separately.)			\$ 73,533	Tuition Reimbursement	(700)	Less: Non-allowable Assn. Dues	(1,998)	
				SMSP Match	71	Less: Public Relations Expense	()	
B. Administrative - Other				Employee Uniforms	10,521	Non-allowable advertising	(33,812)	
Description			Amount	Home Office Allocation	25,262	Yellow page advertising	()	
Various Home Office Services - See page 8 for breakdown			\$ 329,731					
Norman Gross (Jan-Apr) Purchase Service Administrator			47,048					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 649,909	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 66,259	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 376,779					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Anspach Meeks Ellenberger LLP	Legal Fees		\$ 69				Out-of-State Travel	\$
Michael T. Mahoney LTD	Legal Fees		560					
Polsinelli Shughart PC	Legal Fees		105					
SNF Global	Legal Fees		20,654				In-State Travel	25,598
(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)							Includes travel expense to the Home Office in Toledo, OH for regional meetings.	
Healthlink Inc.	Collection Services		81					
Michael t. Mahoney LTD	Collection Services		2,629				Seminar Expense	
Transworld Systems Inc.	Collection Services		1,165					
Medical Collection Group LLC	Collection Services		100					
(Collection Costs were adjusted off via Page 5a, Line 4)								
Michigan Peer Review Organization	Consultation Fees		980				Entertainment Expense	()
(Consultation Fees were reclassified to Line 21)							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 25,598
(For legal fee disclosure, see page 39 of instructions)			\$ 26,343					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heartland of Paxton

0049494

Report Period Beginning:

01/01/15

Ending:

12/31/15

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. ICHA \$2486 & AHCA \$1558
- (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. \$ 36,881 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. \$ 187,908
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. \$ 11,306
- (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.