FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0002923

Facility Name: Heartland Manor Nursing Center

Address: 410 NW Third Box 10 (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (217) 932-4081 **Fax #** (217) 932-4922

HFS ID Number:

Date of Initial License for Current Owners: 12/18/64

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2015 to 06/30/2016 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	81	Skilled (SNF)	81	29,646	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	81	TOTALS	81	29,646	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,024	9,265	2,588	19,877	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,024	9,265	2,588	19,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.05%

D. How many bed-hold days during this year were paid by the Department?
None (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)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 12/16/64

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 35 and days of care provided 2,588

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	265,168	23,607	5,998	294,773		294,773		294,773			1
2	Food Purchase		150,617		150,617		150,617	(23,291)	127,326			2
3	Housekeeping	83,715	17,574	50	101,339		101,339		101,339			3
4	Laundry	65,658	10,107	653	76,418		76,418		76,418			4
5	Heat and Other Utilities			102,777	102,777		102,777	(4)	102,773			5
6	Maintenance	59,742	8,584	35,632	103,958		103,958	1,675	105,633			6
7	Other (specify):* Trash/Waste Disposal			3,923	3,923		3,923		3,923			7
8	TOTAL General Services	474,283	210,489	149,033	833,805		833,805	(21,620)	812,185			8
	B. Health Care and Programs											
9	Medical Director			8,663	8,663		8,663		8,663			9
10	Nursing and Medical Records	1,257,887	75,353	3,290	1,336,530		1,336,530		1,336,530			10
10a	Therapy											10a
11	Activities	51,943	3,349	1,744	57,036		57,036		57,036			11
12	Social Services	52,724		1,744	54,468		54,468		54,468			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,362,554	78,702	15,441	1,456,697		1,456,697		1,456,697			16
	C. General Administration											
17	Administrative	63,064			63,064		63,064		63,064			17
18	Directors Fees											18
19	Professional Services			35,949	35,949		35,949	698	36,647			19
20	Dues, Fees, Subscriptions & Promotions			24,157	24,157		24,157	(5,728)	18,429			20
21	Clerical & General Office Expenses	98,361	10,835	23,375	132,571		132,571	(732)	131,839			21
22	Employee Benefits & Payroll Taxes			302,285	302,285		302,285	7,288	309,573			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,220	8,220		8,220	(549)	7,671			24
25	Other Admin. Staff Transportation			1,307	1,307		1,307		1,307			25
26	Insurance-Prop.Liab.Malpractice			52,498	52,498		52,498		52,498			26
27	Other (specify):*											27
28	TOTAL General Administration	161,425	10,835	447,791	620,051		620,051	977	621,028			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,998,262	300,026	612,265	2,910,553		2,910,553	(20,643)	2,889,910			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.

Facility Name & ID Number Heartland Manor Nursing Center #0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			82,138	82,138		82,138	4,766	86,904			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,460	32,460		32,460	(2,683)	29,777			32
33	Real Estate Taxes			4,085	4,085		4,085	(4,085)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,440	22,440		22,440		22,440			35
36	Other (specify):*											36
37	TOTAL Ownership			141,123	141,123		141,123	(2,002)	139,121			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,869	382,049	479,918		479,918		479,918			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			149,394	149,394		149,394		149,394			42
43	Other (specify):* Non-Allowable Cos			96,844	96,844		96,844	(96,844)				43
44	TOTAL Special Cost Centers		97,869	628,287	726,156		726,156	(96,844)	629,312			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,998,262	397,895	1,381,675	3,777,832		3,777,832	(119,489)	3,658,343			45

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,549)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,766	30		9
10	Interest and Other Investment Income	(6,026)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,467)	43		24
25	Fund Raising, Advertising and Promotional	(5,851)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(30,362)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (119,489)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (119,489)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Ancillary Expense	$ (8,977)	43	1
2	Non Care Real Estate Taxes	(4,085)	33	2
3	Revenue Offset to Food	(16,003)	2	3
4	Reclass Asset	1,675	6	4
5	Revenue Offset to Misc Exp	(732)	21	5
6	Chamber & Rotary Dues	(90)	20	6
7	Nonallowable PAC Dues	(2,146)	20	7
8	Offset Rental Income	(4)	5	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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32				32
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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**	(30,362)		49

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		N/A		N/A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bruce Brown	President	Administrative	0.00	N/A	N/A	N/A	N/A	$ N/A	N/A	1
2	Marcia Vidoni	Vice-President	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	2
3	Erik Huddlestun	Secretary	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	3
4	Sarah Holsapple-Miller	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	4
5	Mike Kirk	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	5
6	Ginny Collins-Knierim	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	N/A	6
7	Bob Dougherty	Director	Administrative	0.00	N/A	N/A	N/A	N/A	N/A	NA	7
8											8
9	*None of the board members have conducted buiness with the facilty.										9
10	*None of the board members have business that have conducted business with the facility.										10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

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 [X]

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

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Preferred Bank		X	Technology	1266.93	12/19/14	$ 66,200	$ 48,237	12/19/19	0.0550	$ 1,349	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Preferred Bank		X	Line of Credit	None	8/31/2013	600,000	566,000	6/30/2017	0.0600	31,515	6
7												7
8	Various		X	Finance Charges							2,154	8
9	TOTAL Facility Related				$1,266.93		$ 666,200	$ 614,237			$ 35,018	9
	B. Non-Facility Related*											
10								Audit adjustment to adjust N/P to actual			(2,558)	10
11								Finance Charges			(529)	11
12								Interest Income			(2,154)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,241)	14
15	TOTALS (line 9+line14)						$ 666,200	$ 614,237			$ 29,777	15

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

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

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	2015	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.)	Alloc. Fr. Mgmt Co.	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012	N/A	9
	2013		10
	2014		11
	2015		12

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

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT Penny Chrysler, Administrator

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on non		$	$
2.	costs are adjusted out of cost repor		$	$
3.			$	$
4.	03-11-19-08-203-046	Lots 8&9 Sturdevant & Goble Addtn	$ 388.46	$
5.	03-11-19-08-203-047	Lots 4&5 Sturdevant & Goble Addtn	$ 1,643.78	$
6.	03-11-19-08-203-049	Lot 2 Sturdevant & Goble Addtn	$ 2,027.92	$
7.	09-36-700-004	SW NE L: RRUSK2&3	$ 25.04	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,085.20	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Resident Care	152,472	1964	$ 24,000	1
2					2
3	TOTALS	152,472		$ 24,000	3

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1964	1964	$ 385,838	$	25	$	$	$ 385,838	4
5			1966	1966	8,491		25			8,491	5
6			1970	1970	3,400		25			3,400	6
7			1972	1972	11,798		25			11,798	7
8	21		1996	1996	828,949	20724	40	20724		414,481	8
	Improvement Type**										
9	Building improvements			1973	7,123		10			7,123	9
10	Building improvements (less disposition of $1,076 in '07-'08)			1974	27,871		14-30			27,871	10
11	Building improvements (less disposition of $1,773 in 2005-06)			1975	5,291		10-30			5,291	11
12	Building improvements			1976	1,607		10-30			1,607	12
13	Building improvements			1977	1,808		7			1,808	13
14	Building improvements (less disposition of $4,880 in 2006-07)			1978	1,281		5-15			1,281	14
15	Building improvements			1979	949		10			949	15
16	Building improvements			1980	5,829		7			5,829	16
17	Building improvements			1981	1,376		7			1,376	17
18	Building improvements			1982	11,926		3-30			11,926	18
19	Building improvements			1983	6,263		5			6,263	19
20	Building improvements (less disposition of $1,974 in 2004-05)			1984	16,740		5-15			16,740	20
21	Building improvements (less disposition of $480 in 2005-06)			1985	5,320		5-15			5,320	21
22	Building improvements (less disposition of $28,007 in 2005-06)			1986	17,785		10-20			17,785	22
23	Building improvements (less disposition of $157 in 2006-07)			1987	27,530		5-15			27,530	23
24	Building improvements			1988	4,282		12-15			4,282	24
25	Building improvements (less disposition of $610 in '07-'08)			1989	2,259		15			2,259	25
26											26
27	Building improvements (less disposition of $2,795 in 2002-03)			1991	631		10			631	27
28	Heating/air system			1992	80,277		20			80,277	28
29	Building improvements			1992	3,084		10			3,084	29
30	Building improvements			1992	2,168		10			2,168	30
31											31
32	Building improvements			1992	647		10			647	32
33	Building improvements			1992	4,263		15			4,263	33
34	Ceiling/floor			1992	49,923		20			49,923	34
35	Sprinkler system			1992	60,121		20			60,121	35
36	Storage shelving			1993	4,090		10			4,090	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 Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	
37	Storage shelving	1993	$ 1,003	$	10	$	$	$ 1,003	37
38	Resident security system	1993	3,909		20			3,909	38
39	Cabinets	1993	42,611		15-20			42,611	39
40	Heating/air/tubs	1993	29,226		20			29,226	40
41	Fire alarm system	1993	12,350		20			12,350	41
42	Plumbing and water system	1993	8,684		20			8,684	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493		20			10,493	44
45	Building improvements	1995	22,859		10-20			22,859	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		36,018	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		14,652	48
49	Sprinklers	1996	9,774	244	40	244		4,636	49
50	Painting	1996	4,052	101	40	101		1,782	50
51	General contractor fees	1996	7,841	196	40	196		3,724	51
52	Electrical	1996	18,390	460	40	460		8,527	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		12,473	53
54	Cubicle curtain tracking	1996	742	32	20	32		742	54
55	Room signs	1996	3,331	161	20	161		3,331	55
56	Emergency lighting Jones wing	1996	142	5	20	5		142	56
57	Bath systems Jones wing	1996	8,610	424	20	424		8,610	57
58	Sprinklers Jones wing	1996	340		10			340	58
59	Security locks Jones wing	1996	1,049	52	20	52		1,043	59
60									60
61	Call lights Jones wing	1996	1,881	94	11	94		1,880	61
62	Air filtration Jones wing	1996	2,081	104	20	104		2,080	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750		10			750	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		2,239	65
66	Plumbing	1996	4,640	32	20	32		4,640	66
67	Electrical work (less disposition of $1,500 in 2005-06)	1996	3,162		20			3,162	67
68	Flooring	1996	2,400	120	20	120		2,380	68
69	Courtyard	1996	2,766	138	20	138		2,752	69
70	TOTAL (lines 4 thru 69)		$ 1,919,114	$ 26,261		$ 26,261	$	$ 1,426,228	70

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 12A, Carried Forward		$ 1,919,114	$ 26,261		$ 26,261	$	$ 1,426,228	1
2	Concrete work entrance	1996	1,470	74	20	74		1,462	2
3	Building appraisal	1997	2,578	64	40	64		512	3
4	Chapel HVAC	1997	2,324	116	20	116		2,267	4
5	Stained glass window	1997	2,052	103	20	103		1,978	5
6	Steel door	1997	422	21	20	21		404	6
7									7
8									8
9	Hand rails	1997	5,252	263	20	263		4,992	9
10									10
11	Walk in cooler	1997	11,524	576	20	576		10,898	11
12	Fire system work	1997	513	26	20	26		486	12
13	Key pad - security system	1997	360	18	20	18		339	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		844	15
16									16
17	Bed light installation	1998	1,826	91	20	91		1,671	17
18	Hand rails	1998	1,413	71	20	71		1,292	18
19	Sprinklers	1998	708	35	20	35		643	19
20	Generator bypass switch	1998	1,567	78	20	78		1,421	20
21									21
22	Lighting - kitchen	1998	985		20			546	22
23	Paging system	1998	516	26	20	26		464	23
24	Room divider remodeling	1998	391	20	20	20		354	24
25	Bathroom lighting	1998	1,090	27	20	55	28	975	25
26	South wing remodeling	1998	165	8	20	8		72	26
27	Roof over generator room	1998	568	28	20	28		503	27
28	Bathrooms	1998	7,394	370	20	370		6,565	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		5,460	29
30	Fire Alarm System	1999	1,317	66	20	66		1,137	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		1,420	31
32		1999	1,760	44	20	88	44	1,511	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,974,070	$ 28,824		$ 28,896	$ 72	$ 1,474,444	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 12B, Carried Forward		$ 1,974,070	$ 28,824		$ 28,896	$ 72	$ 1,474,444	1
2	Generator panel	2000	2,023		10			2,023	2
3	Gazebo	2000	2,733		10			2,733	3
4	Anti-scald valves (2)	2001	655		10			655	4
5	Shower floor replacement	2001	500	25	20	25		388	5
6	Dining room lights	2001	6,013	150	20	301	151	4,663	6
7									7
8	Toilet stools & seats	2001	1,414		10			1,414	8
9	Parking lot asphalt reseal	2001	5,032	252	20	251	(1)	3,706	9
10	Ceramic wall tile	2001	365	18	20	18		267	10
11	Washer & nurse call	2001	485		10			485	11
12	Bath fans	2001	150		10			150	12
13	Extend legs on links	2001	607		10			607	13
14	Wallpaper front lobby	2001	150		10			150	14
15	Remodel North & South showers	2002	2,332	117	20	116	(1)	1,657	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912		10			912	16
17	Water heater	2002	4,165	104	20	208	104	2,931	17
18									18
19	Compressor - freezer	2002	810		10			810	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		471	20
21	Carpet	2003	2,887	144	20	144		1,982	21
22	Bypass switch for generator	2003	2,166	108	20	108		1,423	22
23	Sign	2003	850		10			850	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		2,383	25
26	Water Heater	2004	6,548	327	20	327		4,117	26
27	Wireless Monitoring System	2004	4,263		10			4,263	27
28	Water heater	2004	3,475	174	20	174		2,159	28
29	Lights, smoke detectors, other	2004	2,562		10			2,562	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		$ 2,033,608	$ 30,484		$ 30,809	$ 325	$ 1,518,205	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 12C, Carried Forward		$ 2,033,608	$ 30,484		$ 30,809	$ 325	$ 1,518,205	1
2	Security fence (less disposition of $2,352 in 2005-06)	2005							2
3	Windows - North wing	2005	5,320	266	20	266		3,170	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		3,172	4
5	Windows - South Wing	2005	5,499	275	15	275		3,231	5
6	Windows - H Wing	2005	4,132	207	20	207		2,414	6
7	Handrails	2005	1,375	92	20	92		1,064	7
8	2 ton compressor	2005	558	37	15	37		483	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		7,041	10
11	Generator	2005	20,000	1,000	10	1,000		20,000	11
12									12
13	Roof	2006	10,657	273	39	273		2,730	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		1,483	14
15									15
16	Roof Repair	2008	4,587	167	27.5	167		1,336	16
17									17
18	Canopy Sprinkler System	2008	9,685	646	15	646		5,060	18
19	Jones Wing Door Alarms	2008	3,706	124	15	247	123	1,873	19
20	Hutton Wing New Doors	2009	5,100	340	15	340		2,550	20
21									21
22	Light Fixtures-All Areas	2010	19,737	1,038	20	987	(51)	6,004	22
23									23
24	Water Heater	2011	4,153	208	20	208		1,144	24
25	Door	2011	2,955	148	15	197	49	1,084	25
26									26
27	Backup Generator Meter	2011	3,467	173	20	173		779	27
28									28
29	Kitchen A/C Unit	2012	7,084	472	15	472		2,124	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,161,456	$ 37,053		$ 37,499	$ 446	$ 1,584,947	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 12D, Carried Forward		$ 2,161,456	$ 37,053		$ 37,499	$ 446	$ 1,584,947	1
2									2
3	Water Heater	2013	4,385	219	20	219		767	3
4	Generator Transfer Switch	2013	2,965	148	20	148		518	4
5	Condensing Unit for Walkway	2013	4,768	318	15	318		1,113	5
6									6
7	Landscaping & fountain in front of facility	2014	7,280	182	20	364	182	910	7
8	Installation of digital phone system	2014	6,262		5	1,252	1,252	3,131	8
9	Wiring and labor for installation of EHR capability	2014	7,241	30	20	362	332	905	9
10	Replace condenser on A/C - Dining Room Area	2014	3,323	12	20	166	154	415	10
11	Front office remodel: carpet, paint & tiling	2014	3157	23	20	158	135	395	11
12									12
13	Water Softener - Mechanical Room	2014	2,642	99	10	132	33	264	13
14	Water Heater Southwest Shower	2014	4,385	146	10	219	73	439	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	To reconcile to financial statements			4522			(4,522)		23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,207,864	$ 42,752		$ 40,838	$ (1,914)	$ 1,593,804	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	$ 242,584	$ 37,986	$ 44,666	$ 6,680	3-20 years	$ 189,040	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	427,551				3-15 years	427,551	73
74								74
75	TOTALS	$ 670,135	$ 37,986	$ 44,666	$ 6,680		$ 616,591	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1994 Ford Van	1995	$ 41,610	$	$	$	5	$ 41,610	76
77	Resident Care	2005 Chevy Venture Van	2014	7,000	1,400	1,400		5	3,500	77
78										78
79										79
80	TOTALS			$ 48,610	$ 1,400	$ 1,400	$		$ 45,110	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)	$ 2,950,609	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,138	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,904	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,766	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,255,505	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	See Schedule 13A Attached	$ 161,400	$ 2,185	$ 120,164	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 161,400	$ 2,185	$ 120,164	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/2016**

Schedule 13A

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

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Aklinski Building	1994	40,045	1,027		(1,027)		22,333
	Aklinski concrete work	1994	3,900	195		(195)		3,835
	Land		30,000			-		30,000
	Repp House	1998	38,500	963		(963)		15,041
	Architect fees for Assisted Living	2005	2,915			-		2,915
	410 NW 3rd Street - Land		46,040			-		46,040
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			**161,400**	**2,185**	**-**	**(2,185)**		**120,164**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 22,440 Description: Please see SCH 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **06/30/2016**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Dishwasher	1,527
Washer/Dryer	3,340
Mattresses	900
CPM Units	1,250
Oxygen Equipment	15,423
Total - Line 16	**22,440**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 39, C3	hrs	$	2,164	$ 117,130	$	2,164	$ 117,130	1
2	Licensed Speech and Language Development Therapist	Ln 39, C3	hrs		502	23,641		502	23,641	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 39, C3	hrs		3,987	241,278		3,987	241,278	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				84,764		84,764	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Ther Supplies	L39, C2					13,105		13,105	12
13	Other (specify):									13
14	TOTAL			$	6,654	$ 382,049	$ 97,869	6,654	$ 479,918	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 Manor Nursing Center **#** 0002923 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2016 **(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	$ 115,596	$ 115,596	1
2	Cash-Patient Deposits	9,103	9,103	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 578,073)	1,071,518	1,071,518	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,781	42,781	6
7	Other Prepaid Expenses	38,804	38,804	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,277,802	$ 1,277,802	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	120,585	24,000	13
14	Buildings, at Historical Cost	2,253,202	2,207,864	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	623,115	718,745	16
17	Accumulated Depreciation (book methods)	(2,147,565)	(2,255,505)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Security Deposits**	334	334	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 849,671	$ 695,438	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,127,473	$ 1,973,240	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 407,003	$ 407,003	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,203	9,203	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,093	128,093	30
31	Accrued Taxes Payable (excluding real estate taxes)	74,433	74,433	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	178,103	178,103	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 796,835	$ 796,835	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	614,237	614,237	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)**	$ 614,237	$ 614,237	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,411,072	$ 1,411,072	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 716,401	$ 562,168	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,127,473	$ 1,973,240	48

***(See instructions.)**

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **06/30/2016**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Balance Transfer Clearing Account	76	76
401k Payables	345	345
Employe Deductions - Credit Union	15	15
Undearned Room Revenue	985	985
Patient Refund Clearing Account	176,682	176,682
Total - Line 36	**178,103**	**178,103**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,277,380	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(609,336)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 668,044	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	48,357	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)**	$ 48,357	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 716,401	24 *

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,725,205	1
2	Discounts and Allowances for all Levels	188,899	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,914,104	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	721,101	6
7	Oxygen	5,730	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 726,831	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	16,003	14
15	Telephone, Television and Radio	2,322	15
16	Rental of Facility Space	11,100	16
17	Sale of Drugs	64,182	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,108	19
20	Radiology and X-Ray		20
21	Other Medical Services	73,276	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 170,991	23
	D. Non-Operating Revenue		
24	Contributions	12,463	24
25	Interest and Other Investment Income***	529	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,992	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	1,271	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,271	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,826,189	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	833,805	31
32	Health Care	1,456,697	32
33	General Administration	620,051	33
	B. Capital Expense		
34	Ownership	141,123	34
	C. Ancillary Expense		
35	Special Cost Centers	576,762	35
36	Provider Participation Fee	149,394	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,777,832	40
41	**Income before Income Taxes (line 30 minus line 40)****	48,357	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 48,357	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,132,374	44
45	Private Pay - Net Inpatient Revenue	1,179,694	45
46	Medicare - Net Inpatient Revenue	602,036	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,914,104	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No ^ **If not, please attach a reconciliation.**

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

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

"^-This entity is a cash basis taxpayer"

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **06/30/2016**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Adult Day Care	92
Oil Income	447
Miscellaneous Income	732
Total - Line 28	**1,271**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,911	2,160	$ 50,978	$ 23.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,772	9,380	188,501	20.10	3
4	Licensed Practical Nurses	18,129	19,591	373,969	19.09	4
5	CNAs & Orderlies	50,982	54,246	579,195	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,088	2,216	28,224	12.74	9
10	Activity Assistants	2,761	2,841	23,719	8.35	10
11	Social Service Workers	2,268	2,904	52,724	18.16	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,160	33,026	15.29	13
14	Head Cook	9,042	9,851	93,675	9.51	14
15	Cook Helpers/Assistants	13,394	15,306	138,467	9.05	15
16	Dishwashers					16
17	Maintenance Workers	3,909	4,370	59,742	13.67	17
18	Housekeepers	9,725	10,147	83,715	8.25	18
19	Laundry	4,002	4,418	65,658	14.86	19
20	Administrator	2,043	2,152	63,064	29.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,863	6,502	74,671	11.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,085	2,258	23,690	10.49	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,024	2,225	23,745	10.67	31
32	Other Health C: MDS Coordinator	2,009	2,289	41,499	18.13	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,967	155,016	$ 1,998,262 *	$ 12.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 5,998	L1, C3	35
36	Medical Director	12	8,663	L9, C3	36
37	Medical Records Consultant	16	2,080	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,210	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,744	L11, C3	44
45	Social Service Consultant	24	1,744	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	184	$ 21,439		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Penny Chrysler	Administrator	0	$ 63,064
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,064

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Quorum Consulting Group	401(k) Administrator	$ 2,742
RSM US LLP	Accounting	13,159
Larson, Woodyard & Henson LLP	Accounting	685
Duane Morris	Legal	18,913
Personal Planners	Consulting	450
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 35,949

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,531
Unemployment Compensation Insurance	
FICA Taxes	178,513
Employee Health Insurance	68,400
Employee Meals	7,288
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	3,630
Labs & Physicals	3,211
Employee Life Insurance	
TOTAL (agree to Schedule V, line 22, col.8)	$ 309,573

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,986
Advertising: Employee Recruitment	549
Health Care Worker Background Check	
(Indicate # of checks performed 6)	194
Patient Background Checks 85	1,360
Miscellaneous Licenses & Fees	4,725
Miscellaneous Dues & Subscriptions	9,606
IL Healthcare Assoc. Dues	5,589
Less: Late Fees	(3,343)
Less: Rotary Dues	(90)
Less: Public Relations Expense	( )
Non-allowable advertising	(2,146)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,430

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,576
Seminar Expense	5,095
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,671

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **06/30/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Quorum Consulting Group	401(k) Administrator	$ 2,742
RSM US LLP	Accounting	$ 13,159
Larson, Woodyard & Henson LLP	Accounting	$ 685
Duane Morris	Legal	$ 18,913
Personal Planners	Consulting	$ 450

Total (agree to Schedule V, line 19, column 3)		$ 35,949
Add:	Reclass Unemployment Fees	$ 698
Total (agree to Schedule V, line 19, column 8)		$ 36,647

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $5,589**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **10,633** Line **L10, C2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **149,394**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **7,288** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **16003**

(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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **RSM US LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees