FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049494

Facility Name: Heartland of Paxton

Address: 1001 East Pells St (Number) | Paxton (City) | 60957 (Zip Code)

County: Ford

Telephone Number: 217-379-4361 **Fax #** 217-379-3325

HFS ID Number:

Date of Initial License for Current Owners: 10/13/1988

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Jeff Lewandowski **Telephone Number:** (419) 252-5736
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 01/01/16 to 12/31/16 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) Martin D. Allen
(Title) Director

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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	106	Skilled (SNF)	106	38,796	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	38,796	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	8,990	7,973	6,985	23,948	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,990	7,973	6,985	23,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.73%

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 [X]

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

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 [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 106 and days of care provided 4,445

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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: 01/01/16 Ending: 12/31/16

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	253,437	18,098	29,754	301,289		301,289		301,289			1
2	Food Purchase		207,432		207,432		207,432	(4,203)	203,229			2
3	Housekeeping	140,998	13,788	1,914	156,700		156,700		156,700			3
4	Laundry	20,168	15,698	2,272	38,138		38,138		38,138			4
5	Heat and Other Utilities			143,409	143,409	1,169	144,578		144,578			5
6	Maintenance	60,685	16,844	90,301	167,830		167,830		167,830			6
7	Other (specify):* Med Waste			665	665		665		665			7
8	TOTAL General Services	475,288	271,860	268,315	1,015,463	1,169	1,016,632	(4,203)	1,012,429			8
	B. Health Care and Programs											
9	Medical Director			560	560		560		560			9
10	Nursing and Medical Records	1,981,907	178,312	165,482	2,325,701	28	2,325,729		2,325,729			10
10a	Therapy	635,392	5,768	8,968	650,128		650,128		650,128			10a
11	Activities	53,342	6,796	380	60,518		60,518		60,518			11
12	Social Services	108,733		7,731	116,464		116,464		116,464			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,779,374	190,876	183,121	3,153,371	28	3,153,399		3,153,399			16
	C. General Administration											
17	Administrative	116,135		310,564	426,699	(136,830)	289,869		289,869			17
18	Directors Fees											18
19	Professional Services			40,054	40,054		40,054	(40,054)				19
20	Dues, Fees, Subscriptions & Promotions			87,778	87,778		87,778	(23,270)	64,508			20
21	Clerical & General Office Expenses	357,428	59,548	203,374	620,350		620,350	(108,678)	511,672			21
22	Employee Benefits & Payroll Taxes			538,142	538,142	23,312	561,454		561,454			22
23	Inservice Training & Education			2,898	2,898		2,898		2,898			23
24	Travel and Seminar			4,188	4,188		4,188		4,188			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			117,671	117,671		117,671		117,671			26
27	Other (specify):*							(127)	(127)			27
28	TOTAL General Administration	473,563	59,548	1,304,669	1,837,780	(113,518)	1,724,262	(172,129)	1,552,133			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,728,225	522,284	1,756,105	6,006,614	(112,321)	5,894,293	(176,332)	5,717,961			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 of Paxton #0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			298,435	298,435	8,963	307,398		307,398			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			334,992	334,992	103,358	438,350	(336,600)	101,750			32
33	Real Estate Taxes			82,104	82,104		82,104		82,104			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			77,206	77,206		77,206		77,206			35
36	Other (specify):*											36
37	**TOTAL Ownership**			792,737	792,737	112,321	905,058	(336,600)	568,458			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		239,622		239,622		239,622		239,622			39
40	Barber and Beauty Shops		855	9,663	10,518		10,518		10,518			40
41	Coffee and Gift Shops	40,885			40,885		40,885		40,885			41
42	Provider Participation Fee			174,539	174,539		174,539		174,539			42
43	Other (specify):* IV | X-Ray & Lab		70,250	20,141	90,391		90,391		90,391			43
44	**TOTAL Special Cost Centers**	40,885	310,727	204,343	555,955		555,955		555,955			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,769,110	833,011	2,753,185	7,355,306		7,355,306	(512,932)	6,842,374			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 of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,203)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(1,536)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(342)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(127)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(468)	21		18
19	Entertainment				19
20	Contributions	(1,358)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(32,996)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(103,789)	21		24
25	Fund Raising, Advertising and Promotional	(23,270)	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	(344,843)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (512,932)		$	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)		10a	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (512,932)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heartland of Paxton

ID# 0049494

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$ 0	11	1
2	Misc. Income	(73)	21	2
3	Vending Income	(707)	21	3
4	Donations Revenue	(405)	21	4
5	Accouning/Collection Fees	(7,058)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(336,600)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(344,843)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,203)	0	0	0	0	0	0	0	0	0	0	(4,203)	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**	(4,203)	0	0	0	0	0	0	0	0	0	0	(4,203)	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	(40,054)	0	0	0	0	0	0	0	0	0	0	(40,054)	19
20	Fees, Subscriptions & Promotions	(23,270)	0	0	0	0	0	0	0	0	0	0	(23,270)	20
21	Clerical & General Office Expenses	(108,678)	0	0	0	0	0	0	0	0	0	0	(108,678)	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):*	(127)	0	0	0	0	0	0	0	0	0	0	(127)	27
28	**TOTAL General Administration**	(172,129)	0	0	0	0	0	0	0	0	0	0	(172,129)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(176,332)	0	0	0	0	0	0	0	0	0	0	(176,332)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland of Paxton # 0049494 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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	(336,600)	0	0	0	0	0	0	0	0	0	0	(336,600)	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**	(336,600)	0	0	0	0	0	0	0	0	0	0	(336,600)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(512,932)	0	0	0	0	0	0	0	0	0	0	(512,932)	45

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL 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. [X] 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 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	See	Home Office Allocation	$ 310,564	HCR Manor Care Services, LLC	100.00%	$ 310,564	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,769,110	Heartland Employment Services, LLC	100.00%	3,769,110		4
5	V	10a	Therapy Management	11,647	Heartland Rehabilitation Services, LLC	100.00%	11,647		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			$ 4,091,321			$ 4,091,321	$ *	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 South Holland IL, LLC	South Holland				1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	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: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

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

	1 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	5	Utilities - Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, &	$ 619,847	$	7,096,113	$ 1,169	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs			7,096,113	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs			7,096,113	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	14,966	9,743	7,096,113	28	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs			7,096,113	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs			7,096,113	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	61,861,920	32,341,614	7,096,113	116,672	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	14,679,699	5,396,995	7,096,113	31,625	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs	2,741,751		7,096,113	25,437	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	5,141,603		7,096,113	9,697	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	6,319,907		7,096,113	13,615	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs			7,096,113	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,762,500,577	561 NFs, HHs, & R	3,929,156		7,096,113	7,410	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	720,726		7,096,113	1,553	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs			7,096,113	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,762,500,577		30,527,148		7,096,113	57,575	22
23	32	Directly Assigned Interest	Not Allocated			18,393,998			45,783	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				31,980,611				24
25	TOTALS					$ 176,931,332	$ 37,748,352		$ 310,564	25

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Various			$ 618,583	$ 579,893		0.0790	$ 45,783	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Pooled Interest										57,575	7
8	Interest Expense / Interest Income										(1,608)	8
9	TOTAL Facility Related						$ 618,583	$ 579,893			$ 101,750	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 618,583	$ 579,893			$ 101,750	15

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

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

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.**	$ 77,350	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.)		$ 79,727	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,377	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 79,727	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.		$ 82,104	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	73,162	8
	2012	73,439	9
	2013	76,118	10
	2014	77,350	11
	2015	79,727	12

Line 2: $79,727.24 = $39,863.62 for 1st half 2015 + $39,863.62 for 2nd half 2015

Line 4: Same as line 2.

	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 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 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.	11-14-08-476-001	See Attached	$ 79,727.24	$ 79,727.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 79,727.24	$ 79,727.24

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 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 of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] (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. [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).

N/A

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	Facility		1988	$ 75,186	1
2					2
3	TOTALS			$ 75,186	3

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	96		1988	1988	$ 1,323,187	$ 157,270		$ 157,270	$	$ 2,941,277	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 Yerar Depreciation					67,869		67,869		1,862,341	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: 01/01/16 Ending: 12/31/16

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	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	CABINETRY & 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	$ 225,139		$ 225,139	$	$ 4,803,618	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: 01/01/16 Ending: 12/31/16

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		$ 5,390,850	$ 225,139		$ 225,139	$	$ 4,803,618	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	$ 225,139		$ 225,139	$	$ 4,803,618	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: 01/01/16 Ending: 12/31/16

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		$ 5,605,697	$ 225,139		$ 225,139	$	$ 4,803,618	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)		$ 5,911,818	$ 225,139		$ 225,139	$	$ 4,803,618	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: 01/01/16 Ending: 12/31/16

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		$ 5,911,818	$ 225,139		$ 225,139	$	$ 4,803,618	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	000000050576 Ren-Gen ovhd capit	2009	33,063						18
19	000000050576 Renovation-interest on const	2009	1,169						19
20	000000050579 Renovation -Carpentry	2009	91,141						20
21	000000050580 Ren-lobby finishes	2009	3,520						21
22	000000050580 Ren-carpeting & pads	2009	12,110						22
23	000000050580 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	$ 225,139		$ 225,139	$	$ 4,803,618	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: 01/01/16 Ending: 12/31/16

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		$ 6,633,730	$ 225,139		$ 225,139	$	$ 4,803,618	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 spnklrs/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	Backflow preventer-west wall in fire pump mechanical room	2016	3,579						26
27	Materials and work for Facility fire alarm system	2016	6,400						27
28	Install life safety panel	2016	3,600						28
29	Install CR Panel - NFPA Generator Corrections	2016	24,000						29
30	Water Softner replacement	2016	13,925						30
31	Access control system - entrance doors/east dining ext doors	2016	23,272						31
32	Replace Water Heaters for Kitchen Area	2016	13,249						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,891,289	$ 225,139		$ 225,139	$	$ 4,803,618	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: 01/01/16 Ending: 12/31/16

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	$ 2,105,932	$ 73,296	$ 73,296	$		$ 1,941,763	71
72	Current Year Purchases	51,020						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			8,963	8,963			74
75	TOTALS	$ 2,156,952	$ 73,296	$ 82,259	$ 8,963		$ 1,941,763	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)	$ 9,123,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 298,435	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 307,398	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,963	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,745,381	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: 01/01/16 Ending: 12/31/16

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

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: $ 55,364 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	2017 Ford T150 Transit V	$	$ 2,457	17
18	Patient Transportation	2009 Ford E-350 (Retired)		19,385	18
19				above figure includes	19
20				gas & maintenance	20
21	TOTAL		$	$ 21,842	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 & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

   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.

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	10a	2272 hrs	$ 90,166		$	$ 288	2,272	$ 90,454	1
2	Licensed Speech and Language Development Therapist	10a	1906 hrs	75,634			318	1,906	75,952	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4430 hrs	175,827			5,162	4,430	180,989	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				239,622		239,622	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Therapy	43, 2					70,250		70,250	12
13	Other (specify): X-Ray & Lab	43, 3				20,141			20,141	13
14	TOTAL			$ 341,627		$ 20,141	$ 315,640	8,608	$ 677,408	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 **#** 0049494 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 41,963	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 233,248)	663,740		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)**	$ 705,703	$	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	6,891,287		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,156,952		16
17	Accumulated Depreciation (book methods)	(6,745,381)		17
18	Deferred Charges	107,986		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,486,030	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,191,733	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 182,482	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	328,935		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,727		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	132,995		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 724,139	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	579,893		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)**	$ 579,893	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,304,032	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,887,701	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,191,733	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,924,529	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,924,529	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(932,248)	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)**	$ (932,248)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(7,104,580)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (7,104,580)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,887,701	24 *

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,583,040	1
2	Discounts and Allowances for all Levels	(2,880,197)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,702,843	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,032,756	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,032,756	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	834	12
13	Barber and Beauty Care	12,323	13
14	Non-Patient Meals	4,203	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	502,696	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,989	19
20	Radiology and X-Ray	15,334	20
21	Other Medical Services	118,066	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 685,445	23
	D. Non-Operating Revenue		
24	Contributions	405	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 405	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscelleanous Inc &Purchase Discount	1,609	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,609	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,423,058	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,015,463	31
32	Health Care	3,153,371	32
33	General Administration	1,837,780	33
	B. Capital Expense		
34	Ownership	792,737	34
	C. Ancillary Expense		
35	Special Cost Centers	381,416	35
36	Provider Participation Fee	174,539	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,355,306	40
41	**Income before Income Taxes (line 30 minus line 40)****	(932,248)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (932,248)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,140,951	44
45	Private Pay - Net Inpatient Revenue	1,764,137	45
46	Medicare - Net Inpatient Revenue	663,207	46
47	Other-(specify) Hospice	83,677	47
48	Other-(specify) Insurance	50,871	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,702,843	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: 01/01/16 Ending: 12/31/16

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	2,099	2,305	$ 84,060	$ 36.47	1
2	Assistant Director of Nursing	3,918	4,303	137,648	31.99	2
3	Registered Nurses	15,409	16,926	495,349	29.27	3
4	Licensed Practical Nurses	20,908	22,966	529,074	23.04	4
5	CNAs & Orderlies	52,349	57,661	730,265	12.66	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	11,294	12,397	492,036	39.69	7
8	Rehab/Therapy Aides	3,994	4,384	143,356	32.70	8
9	Activity Director	3,424	3,767	53,342	14.16	9
10	Activity Assistants					10
11	Social Service Workers	5,670	6,239	108,733	17.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,748	20,624	253,437	12.29	15
16	Dishwashers					16
17	Maintenance Workers	2,192	2,410	60,685	25.18	17
18	Housekeepers	11,654	12,817	140,998	11.00	18
19	Laundry	1,902	2,092	20,168	9.64	19
20	Administrator	2,080	2,080	105,910	50.92	20
21	Assistant Administrator	354	354	10,225	28.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,132	16,712	357,428	21.39	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	365	401	5,511	13.74	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	2,487	2,735	40,885	14.95	33
34	TOTAL (lines 1 - 33)	173,979	191,173	$ 3,769,110 *	$ 19.72	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		$		35
36	Medical Director	Monthly	560	9, 3	36
37	Medical Records Consultant	Monthly	2,691	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)		$ 3,251		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Clarence E. Boykin (Jan-June)	Administrator	0	$ 52,889
Deborah Hilgenberg (June-Dec)	Administrator	0	53,021
Donna M. Kinkade	Asst. Administrator	0	10,225
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 116,135

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 310,564
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 310,564

C. Professional Services

Vendor/Payee	Type	Amount
Kathleen W Kolodgy Esq	Legal Fees	$ 275
SNF Global	Legal Fees	32,721
(Legal fees were adjusted off via page 5 line 22, therefore, no invoices are attached)		
Medical Collection Group LLC	Collection Services	90
Michael T. Mahoney LTD	Collection Services	5,624
Transworld Systems Inc	Collection Services	1,344
(Collections costs were adjusted off via Page 5a, line 5)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 40,054

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,132
Unemployment Compensation Insurance	45,976
FICA Taxes	264,702
Employee Health Insurance	176,782
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	10,425
Appreciation, Oth Benefits & Mktg Adj	12,895
Tuition Program	(900)
Smsp Match	318
Employee Uniforms	5,812
Home Office Allocation	23,312
TOTAL (agree to Schedule V, line 22, col.8)	$ 561,454

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	37,856
Health Care Worker Background Check	4,981
(Indicate # of checks performed 184)	
Patient Background Checks 487	4,870
Dues & Subscriptions	7,753
Association Dues	6,646
Advertising	20,988
Other Licenses and Permits	704
Less: Non-Allowable Association Dues	(2,282)
Less: Public Relations Expense	( )
Non-allowable advertising	(20,988)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 64,508

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,188
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,188

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 $2,809 & ACHA $1,555**

(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. $ **33,435** 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. $ **174,539**
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. $ **4,203**

(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