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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0049452

Facility Name: Heartland of Henry

Address: 1650 Indian Town Rd (Number) Henry (City) 61537 (Zip Code)

County: Marshall

Telephone Number: (309) 364-3905 **Fax #** (309) 364-3119

HFS ID Number:

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

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 01/01/17 to 12/31/17 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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 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	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,083	9,703	6,078	23,864	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,083	9,703	6,078	23,864	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.55%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 04/01/1989

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 62 and days of care provided 3,592

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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	231,791	12,385	9,580	253,756		253,756		253,756			1
2	Food Purchase		162,897		162,897		162,897	(3,793)	159,104			2
3	Housekeeping	82,256	11,721	2,241	96,218		96,218		96,218			3
4	Laundry	51,107	10,457		61,564		61,564		61,564			4
5	Heat and Other Utilities			119,483	119,483	1,215	120,698		120,698			5
6	Maintenance	70,121	27,732	38,170	136,023		136,023		136,023			6
7	Other (specify):* Medical Waste			435	435		435		435			7
8	TOTAL General Services	435,275	225,192	169,909	830,376	1,215	831,591	(3,793)	827,798			8
	B. Health Care and Programs											
9	Medical Director			5,922	5,922		5,922		5,922			9
10	Nursing and Medical Records	1,721,371	102,838	25,194	1,849,403	128	1,849,531		1,849,531			10
10a	Therapy	552,500	4,453	8,627	565,580		565,580		565,580			10a
11	Activities	85,226	1,773	1,509	88,508		88,508		88,508			11
12	Social Services	86,868	38	786	87,692		87,692		87,692			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,445,965	109,102	42,038	2,597,105	128	2,597,233		2,597,233			16
	C. General Administration											
17	Administrative	72,507		246,630	319,137	(86,570)	232,567		232,567			17
18	Directors Fees											18
19	Professional Services			61,777	61,777	(100)	61,677	(61,677)				19
20	Dues, Fees, Subscriptions & Promotions			62,609	62,609		62,609	(32,776)	29,833			20
21	Clerical & General Office Expenses	172,100	27,353	186,760	386,213		386,213	(138,645)	247,568			21
22	Employee Benefits & Payroll Taxes			475,261	475,261	22,513	497,774		497,774			22
23	Inservice Training & Education			882	882		882		882			23
24	Travel and Seminar			10,362	10,362		10,362		10,362			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,550	17,550		17,550		17,550			26
27	Other (specify):*							(73)	(73)			27
28	TOTAL General Administration	244,607	27,353	1,061,831	1,333,791	(64,157)	1,269,634	(233,171)	1,036,463			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,125,847	361,647	1,273,778	4,761,272	(62,814)	4,698,458	(236,964)	4,461,494			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 Henry #0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			182,646	182,646	7,462	190,108		190,108			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,233,325	1,233,325	55,352	1,288,677	(1,233,876)	54,801			32
33	Real Estate Taxes			122,402	122,402		122,402		122,402			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,510	21,510		21,510		21,510			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,559,883	1,559,883	62,814	1,622,697	(1,233,876)	388,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,280	(398)	106,882		106,882		106,882			39
40	Barber and Beauty Shops			15,776	15,776		15,776		15,776			40
41	Coffee and Gift Shops	17,472			17,472		17,472		17,472			41
42	Provider Participation Fee			174,778	174,778		174,778		174,778			42
43	Other (specify):* IV | X-Ray & Lab		23,470	27,253	50,723		50,723		50,723			43
44	**TOTAL Special Cost Centers**	17,472	130,750	217,409	365,631		365,631		365,631			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,143,319	492,397	3,051,070	6,686,786		6,686,786	(1,470,840)	5,215,946			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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,793)	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	(880)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(328)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(73)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,358)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(56,746)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(134,872)	21		24
25	Fund Raising, Advertising and Promotional	(32,776)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pg. 5A	(1,240,014)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,470,840)		$	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))**	$ (1,470,840)		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 Henry

ID# 0049452

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	(567)	21	3
4	Donations Revenue	(640)	21	4
5	Accouning/Collection Fees	(4,931)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(1,233,876)	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**	(1,240,014)		49

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HCR Manor Care Svcs	Toledo	Therapy Mgmt Svcs
				HL Home Health Care	Toledo	Nursing Staff

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 246,630	HCR Manor Care Services, LLC	0.00%	$ 246,630	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,143,319	Heartland Employment Services, LLC	0.00%	3,143,319		4
5	V	10a	Therapy Management	12,706	HCR Manor Care Services, LLC	0.00%	12,706		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,402,655			$ 3,402,655	$ *	14

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	3,738,067,390	560 NFs, HHs, &	$ 699,205	$ 0	6,496,852	$ 1,215	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	6,496,852	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	6,496,852	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	16,031	10,238	6,496,852	28	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	6,496,852	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	6,496,852	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	59,973,786	32,867,234	6,496,852	104,236	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	16,450,188	6,362,586	6,496,852	32,932	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	2,602,958	0	6,496,852	22,892	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	5,900,308	0	6,496,852	10,255	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	6,123,085	0	6,496,852	12,258	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	0	0	6,496,852	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	3,462,953	0	6,496,852	6,018	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	721,157	0	6,496,852	1,444	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	6,496,852	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,738,067,390		28,591,078		6,496,852	49,692	22
23	32	Directly Assigned Interest	Not Allocated			16,243,764			5,660	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,016,444				24
25	TOTALS					$ 174,800,956	$ 39,240,058		$ 246,630	25

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 81,733	$ 73,141		0.0774	$ 5,660	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										49,692	6
7	Interest Income / Interest Expense										(551)	7
8												8
9	TOTAL Facility Related						$ 81,733	$ 73,141			$ 54,801	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 81,733	$ 73,141			$ 54,801	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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 128,207	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.)		$ 125,304	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,902)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 125,304	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.		$ 122,402	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	124,844	8
	2013	124,514	9
	2014	124,877	10
	2015	128,207	11
	2016	125,304	12

Line 2: $125,304.46 = $62,652.23 for 1st half 2016 + $62,652.23 for 2nd half 2016

Line 4: Used same amounts as line 2.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland of Henry COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0049452

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-09-326-001	See Attached	$ 125,304.46	$ 125,304.46
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 125,304.46	$ 125,304.46

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,130 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [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).

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	Facility		1988	$ 174,000	1
2					2
3	TOTALS			$ 174,000	3

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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	93		1988	1988	$ 1,748,953	$ 53,363		$ 53,363	$	$ 1,429,857	4
5	1			2005	342,188						5
6	7/1/06 Capital Rate Adjust #5			2005	43,364						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					90,789		90,789		1,864,133	9
10	Bldg Equip Miscoded to Bldg Improv-Moved To Equip (1988-1993)			1988	(161,519)						10
11	Land/Bldg Improvement (See attached schedule)			1988	487,372						11
12	Door Monitor			1989	2,438						12
13	Land/Bldg. Improvement (See attached schedule)			1990	242						13
14	Land/Bldg. Improvement (See attached schedule)			1991	9,067						14
15	Land/Bldg. Improvement (See attached schedule)			1992	8,628						15
16	Land/Bldg. Improvement (See attached schedule)			1993	19,910						16
17	Move Const Cost From CIP			1993	46,289						17
18	7/1/03 Audit Adj (#1) - Constr Cost			1993	(46,289)						18
19	Land/Bldg. Improvement (See attached schedule)			1994	3,550						19
20	Land/Bldg. Improvement (See attached schedule)			1995	7,068						20
21	(24) DOORS			1996	1,136						21
22	ADDITIONAL COST WALLCOVERING			1996	19						22
23	CARPET			1996	863						23
24	HVAC UPGRADE			1996	2,946						24
25	SEWER LINE CONNECTION			1996	2,398						25
26	SANITARY SEWER			1996	13,155						26
27	SEALCOAT & STRIPE PARKING LOT			1996	3,114						27
28	WALLCOVERING			1997	9,801						28
29	WALLCOVERING			1997	9,019						29
30	PAINTING & WALLCOVERING			1997	13,132						30
31	CROWN MOLDING FOR RENOVATION			1997	198						31
32	CARPET & WALLCOVERING			1997	3,245						32
33	VINYL WALL COVERING FROM INVENTORY			1997	343						33
34	ADDL'T COST FOR HOT WATER			1997	4,822						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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	THERMOSTATIC MIXING VALVE	1998	$ 15,929	$		$	$	$	37
38	MIXING VALVES	1998	4,076						38
39	A/C	1998	272,596						39
40	7/1/03 AUDIT ADJ (#2) - A/C	1998	(10,454)						40
41	NURSES STATION CEILING	1998	5,071						41
42	FENCE	1998	6,950						42
43	CONSTRUCTION OVERHEAD	1999	11,664						43
44	7/1/03 AUDIT ADJ (#3) - CONSTR OVERHEAD	1999	(11,664)						44
45	DOORS	1999	4,837						45
46	INSULATION	1999	10,367						46
47	CUSTOM CABINETS	1999	5,975						47
48	HVAC	1999	1,475						48
49	WATER PROOFING FOR RENOVATION	1999	1,295						49
50	CARPET	1999	13,794						50
51	LOREN COOK ROOF EXHAUST	1999	1,325						51
52	WATER PROOFING FOR SHOWER	1999	3,555						52
53	SHOWER AND TOILET INSTALLATION	1999	3,738						53
54	SHOWER AND TOILET INSTALLATION	1999	1,009						54
55	SHOWER AND TOILET INSTALLATION	1999	6,392						55
56	CARPET	1999	395						56
57	CARPET	1999	256						57
58	CARPET	1999	2,658						58
59	DOOR ALARM ANNUNCIATOR	1999	4,822						59
60	7/1/03 AUDIT ADJ (#4) - DOOR ALARM	1999	(4,822)						60
61	SEALCOATING	1999	5,203						61
62	ROOFING	2000	6,824						62
63	CONSTRUCTION AND DESIGN OVERHEAD COSTS	2000	6,911						63
64	7/1/03 AUDIT ADJ (#5) - CONSTR OVERHEAD	2000	(6,911)						64
65	WALLCOVERING	2000	1,569						65
66	ADDL'T CERAMIC TILE	2000	1,009						66
67	INSTALL GROUND FAULT INTERRUPTOR PROTECTION	2000	1,668						67
68	DOORS	2000	5,492						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,948,456	$ 144,152		$ 144,152	$	$ 3,293,990	70

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 2,948,456	$ 144,152		$ 144,152	$	$ 3,293,990	1
2	PAINTING	2000	3,000						2
3	PAINTING FOR RESIDENTS ROOMS	2000	906						3
4	DOOR HARDWARE	2000	730						4
5	PAINTING	2000	3,000						5
6	PAINTING	2000	(3,000)						6
7	DRYWALL	2000	7,280						7
8	SMOKE DAMPERS	2000	658						8
9	ADDL'T COST SMOKE DAMPERS	2000	73						9
10	TOTAL DOORS	2000	610						10
11	WALLCOVERING	2000	170						11
12	WALLCOVERING	2000	709						12
13	WALLCOVERING	2000	519						13
14	WALLCOVERING	2000	299						14
15	CEILING	2001	1,225						15
16	CUSTOM WORKSTATION	2001	2,067						16
17	PAINT & WALLCOVERING	2001	1,760						17
18	WALLCOVERING - LOUNGE RENOVATION	2001	557						18
19	WINDOWS	2001	855						19
20	HOT WATER HEATERS	2001	7,900						20
21	DRAPES	2001	2,980						21
22	CARPET	2001	29,586						22
23	ADDTL COSTS FOR CARPET	2001	2,260						23
24	CARPET	2001	500						24
25	WALLCOVERING	2001	516						25
26	WALLCOVERING	2001	90						26
27	CARPENTRY - LOUNGE RENOVATION	2001	6,002						27
28	DRAPES, SHADES, BLINDS - LOUNGE RENOVATION	2001	1,109						28
29	CARPENTRY, DRYWALL, STUDS - LOUNGE RENOVATION	2001	10,360						29
30	PAINTING, WALLCOVERING - LOUNGE RENOVATION	2001	9,691						30
31	PLUMBING - LOUNGE RENOVATION	2001	4,425						31
32	CONCRETE	2001	2,248						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,047,541	$ 144,152		$ 144,152	$	$ 3,293,990	34

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 3,047,541	$ 144,152		$ 144,152	$	$ 3,293,990	1
2	CPQ SUC PK 3YR	2001	932						2
3	7/1/06 CAPITAL RATE ADJUST #1	2001	(932)						3
4	ROOFING	2002	12,870						4
5	INSTALL LIGHTING	2002	2,065						5
6	FLOORING,PAINTING,VWC	2002	16,778						6
7	ARTWORK	2002	1,390						7
8	7/1/03 AUDIT ADJ (#6) - ARTWORK	2002	(1,390)						8
9	ROOF	2003	57,188						9
10	7/1/06 CAPITAL RATE ADJUST #2	2003	(2,316)						10
11	OVERHEAD & INTEREST	2003	224						11
12	7/1/03 AUDIT ADJ (#7) - OVERHEAD & INTEREST	2003	(224)						12
13	ADDITIONAL ROOF COSTS	2003	16,778						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(522)						14
15	MAIN DINING/LOUNGE VWC, FLOORING, PAINT	2003	23,253						15
16	MAIN DINING/LOUNGE VINYL WALL COVERING	2003	5,321						16
17	DOORS	2003	5,757						17
18	OUTDOOR SECURITY LIGHTING	2003	6,525						18
19	OUTDOOR SECURITY LIGHTING	2003	725						19
20	ASPHALT, SEAL & STRIPE PARKING LOT	2003	5,865						20
21	Bathroom doors, locks, & Floor	2003	40,831						21
22	Resilient Flooring	2004	22,526						22
23	7/1/06 CAPITAL RATE ADJUST #4	2004	(3,171)						23
24	Automatic Door	2004	4,630						24
25	Electrical	2004	1,440						25
26	Wallcovering	2004	397						26
27	Vinyl Wall Covering	2004	72						27
28	Vinyl Wall Covering	2004	162						28
29	Vinyl Wall Covering	2004	62						29
30	Vinyl Wall Covering & Border	2004	3,260						30
31	Vinyl Wall Covering	2004	229						31
32	Credits on Wallcovering	2004	(18)						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,268,248	$ 144,152		$ 144,152	$	$ 3,293,990	34

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 3,268,248	$ 144,152		$ 144,152	$	$ 3,293,990	1
2	Cove Base	2004	400						2
3	Smoke Dampers	2004	1,996						3
4	Smoke Dampers	2004	222						4
5	Flooring, VCT	2004	10,420						5
6	Exit Lights	2004	1,480						6
7	Parking Light Fixtures	2005	4,120						7
8	Site concrete, site preparation	2005	43,364						8
9	7/1/06 CAPITAL RATE ADJUST #6	2005	(43,364)						9
10	Field testing, Foundation testing	2005	4,234						10
11	Excavation, Paving	2005	17,775						11
12	Excavation, Paving	2005	16,609						12
13	Windows	2005	2,675						13
14	Painting	2005	7,200						14
15	Freight on Carpet	2005	348						15
16	General Overhead & Interest	2005	132,007						16
17	7/1/06 CAPITAL RATE ADJUST #7	2005	(132,007)						17
18	Vinyl Wall Covering, Flooring	2005	5,764						18
19	Doors	2005	5,995						19
20	Remove and Install Floor	2005	3,689						20
21	Wall covering, Carpet Pads	2005	33,481						21
22	7/1/06 CAPITAL RATE ADJUST #8	2005	(1,520)						22
23	Custom Cabinets, tops, nursing sta	2005	26,300						23
24	Electrical, emergency power system	2005	91,051						24
25	Overhead, Interest, Engineering cost	2005	24,303						25
26	7/1/06 CAPITAL RATE ADJUST #9	2005	(16,053)						26
27	Generator Installation	2005	5,886						27
28	Generator Installation	2005	5,462						28
29	New Garage Roof	2006	900						29
30	2 Wood Doors	2006	2,430						30
31	Ceiling Tiles for Corridor	2006	4,441						31
32	Wallcovering	2006	626						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,528,482	$ 144,152		$ 144,152	$	$ 3,293,990	34

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 3,528,482	$ 144,152		$ 144,152	$	$ 3,293,990	1
2	Wallcovering	2006	425						2
3	Wallcovering	2006	2,625						3
4	Wallcovering	2006	3,625						4
5	Handrail	2006	27,820						5
6	Wallcovering	2006	268						6
7	Wallcovering	2006	647						7
8	Building Improv - Shower	2006	9,648						8
9	6 PTAC Units	2006	3,950						9
10	Fencing	2006	1,295						10
11	CONCRETE UNDER TRANSFER S	2006	2,160						11
12	0607 RES RM RENOV - LIGHT FIXTURES	2007	2,539						12
13	0607 RES RM RENOV - COUNTER & SINK	2007	9,300						13
14	0607 RES RM RENOV - TOILET	2007	6,660						14
15	0607 RES RM RENOV - WALL HEATER	2007	6,000						15
16	0607 RES RM RENOV - PAINTING	2007	3,261						16
17	0607 RES RM RENOV - VINYL FLOORING	2007	6,131						17
18	0607 RES RM RENOV - WALL CABINETS	2007	3,000						18
19	0607 RES RM RENOV - GENL CONDITNING	2007	4,033						19
20	2 concrete sidewalks	2008	2,600						20
21	CARPENTRY	2008	500						21
22	0907 EMERGENCY LIGHTING	2008	6,357						22
23	0907 EMERGENCY LIGHTING	2008	38,409						23
24	0907 EMERGENCY LIGHTING	2008	6,454						24
25	0907 EMERGENCY LIGHTING	2008	4,450						25
26	AC CONDENSING UNIT	2008	4,287						26
27	ELECTRICAL FOR TVS	2008	10,260						27
28	SERVICE DOOR ENTRANCE1	2008	5,365						28
29	FIRE RATED SHUTTER	2008	4,806						29
30	DOOR FOR ENTRANCE	2008	5,365						30
31	Entrance Doors	2008	1,000						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,711,722	$ 144,152		$ 144,152	$	$ 3,293,990	34

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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 12E, Carried Forward		$ 3,711,722	$ 144,152		$ 144,152	$	$ 3,293,990	1
2	BI 022449 0309 FLOORING REPLACEMENT	2010	25,203						2
3	LI 022448 back door concrete pad	2010	4,246						3
4	LI 022459 5' wide sidewalk, therapy	2010	4,038						4
5	LI 022460 Seal & strip pkg lot	2010	4,978						5
6	BI 022463 Radiant Heat Panels	2011	7,450						6
7	BI 022469 135 Sprinkler Heads	2011	10,215						7
8	BI 022481 PT reno-prime/paint ceilings, vwc removal	2011	41,370						8
9	BI 022482 0211 PARKING LOT	2011	83,215						9
10	BI 022484 Wallcovering	2011	19,675						10
11	000000022490 GAS WATER HEATER	2012	5,395						11
12	000000022496 0212 Nurse Call System	2012	1,353						12
13	000000022497 0112 Fire Alarm System	2012	38,093						13
14	000000022498 0112 Fire Alarm System	2012	1,184						14
15	000000022499 ADJ ASSET #22497-fire alarm system	2012	2,898						15
16	000000022500 ADJ ASSET #22497-fire alarm system	2012	6,762						16
17									17
18	22508 Freight for flooring	2013	1,338						18
19	22510 FLOORING - tile for bath/res rm	2013	10,173						19
20	22511 22 RES RM BATH FLOORING	2013	18,357						20
21	22513 22 RESIDENT ROOM FLOORING	2013	6,054						21
22	22517 Water Heater 100, 300 Theray, + Laundry	2013	6,200						22
23	22520 A#22511 RES RM BATH FLOORING	2013	12,188						23
24									24
25	400 Hall Res. Rms - Resilient Flooring	2014	15,520						25
26	400 Hall Res. Rms - Carpeting & Pads	2014	1,399						26
27	400 Hall Res. Rms - Paint & Wall Covering	2014	43,416						27
28	003-14MW 400 Hall Res. Rms - Light Fixtures	2014	11,863						28
29	Pipes for Sprinklers - Wings 100, 200 & 400 (1of3)	2015	3,106						29
30	Pipes for Sprinklers - Wings 100, 200 & 400 (2of3)	2015	8,339						30
31	Water Heater BTR-200 for Kithchen	2015	5,931						31
32	400 Hall Res Rms - Crash Rails, Drywall Repair & Paint	2014	6,165						32
33	400 Hall Drapes/Shades/Blinds	2014	3,791						33
34	TOTAL (lines 1 thru 33)		$ 4,121,637	$ 144,152		$ 144,152	$	$ 3,293,990	34

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 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 12F, Carried Forward		$ 4,121,637	$ 144,152		$ 144,152	$	$ 3,293,990	1
2	Generator Panel & Wiring	2015	5,760						2
3	Pipes for Sprinklers - Wings 100, 200 & 400 (3of3)	2015	13,169						3
4	Damper Motor - Kitchen/Mechanical Room	2015	1,027						4
5	HVAC Compressor for unit RT-9702 Model 17358	2015	1,530						5
6	Electrical Wiring for Computers	2015	10,890						6
7	Sprinkler Heads (58) & Dry Pendent Heads (9)	2015	5,022						7
8	Vinyl Fence	2015	2,935						8
9	LED Light Fixtures for parking lot	2015	4,694						9
10									10
11	Replace 4 Centrifugal Downblast Roof Exhaust Fans	2016	4,500						11
12	Water Heater in 400 Hall, AO Smith 80 gallon	2016	3,833						12
13	Repair Drywall then Paint Walls, Floors, & Ceiling in Laundry Room	2016	11,200						13
14	Replace Drywall, Fire Tape/caulk, & Paint Ceilings in Hallways	2016	18,200						14
15									15
16	AHU 10T HVAC System placed above business office	2017	17,000						16
17	Emerg Fire rated Doors & exit devices-Employee ent ext & int, outpt t	2017	23,864						17
18	Secure care exit unit w/keypads in south wing outside exit	2017	9,525						18
19	Metal door 400 hall	2017	5,609						19
20	Hot water heater off dining room	2017	7,260						20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 4,267,655	$ 144,152		$ 144,152	$	$ 3,293,990	34

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,963,261	$ 38,494	$ 38,494	$		$ 1,853,478	71
72	Current Year Purchases	35,163						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			7,462	7,462			74
75	TOTALS	$ 1,998,424	$ 38,494	$ 45,956	$ 7,462		$ 1,853,478	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,440,079	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,646	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,108	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,462	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,147,468	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 12,987 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	2013 Dodge Grand Carava	$	$ 8,523	17
18					18
19				above amount includes	19
20				gas & maintenance too	20
21	TOTAL		$	$ 8,523	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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1812 hrs	$ 76,614		$	$ 118	1,812	$ 76,732	1
2	Licensed Speech and Language Development Therapist	10a	930 hrs	39,333				930	39,333	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2103 hrs	88,938			4,335	2,103	93,273	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				107,280		107,280	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3			140	8,690		140	8,690	12
13	Other (specify): X-Ray & Lab | IV	43, 3 & 2				27,253	23,470		50,723	13
14	TOTAL			$ 204,885	140	$ 35,943	$ 135,203	4,985	$ 376,031	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.

STATE OF ILLINOIS

Facility Name & ID Number Heartland of Henry **#** 0049452 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 15,139	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 188,207)	578,711		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,844		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 604,694	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	174,000		13
14	Buildings, at Historical Cost	4,267,654		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,998,424		16
17	Accumulated Depreciation (book methods)	(5,147,468)		17
18	Deferred Charges	105,736		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 OMIT	45,390		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,443,736	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,048,430	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,121	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	304,215		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,304		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	73,210		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 608,850	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	73,141		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 73,141	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 681,991	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,366,439	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,048,430	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,580,332	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,580,332	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(595,276)	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)**	$ (595,276)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	381,383	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 381,383	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,366,439	24 *

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 6,014,572	1
2	Discounts and Allowances for all Levels	(2,211,343)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,803,229	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,956,753	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,956,753	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	640	12
13	Barber and Beauty Care	20,535	13
14	Non-Patient Meals	3,793	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	214,442	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,631	19
20	Radiology and X-Ray	10,148	20
21	Other Medical Services	32,819	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 330,008	23
	D. Non-Operating Revenue		
24	Contributions	640	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 640	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discount	880	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 880	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,091,510	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	830,376	31
32	Health Care	2,597,105	32
33	General Administration	1,333,791	33
	B. Capital Expense		
34	Ownership	1,559,883	34
	C. Ancillary Expense		
35	Special Cost Centers	190,853	35
36	Provider Participation Fee	174,778	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,686,786	40
41	**Income before Income Taxes (line 30 minus line 40)****	(595,276)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (595,276)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,088,536	44
45	Private Pay - Net Inpatient Revenue	2,049,425	45
46	Medicare - Net Inpatient Revenue	360,571	46
47	Other-(specify) Hospice	130,124	47
48	Other-(specify) Insurance	174,573	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,803,229	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,734	1,912	$ 90,465	$ 47.31	1
2	Assistant Director of Nursing	3,236	3,567	124,734	34.97	2
3	Registered Nurses	18,857	20,784	520,597	25.05	3
4	Licensed Practical Nurses	12,731	14,032	309,135	22.03	4
5	CNAs & Orderlies	46,887	51,758	642,342	12.41	5
6	CNA Trainees					6
7	Licensed Therapist	7,089	7,797	329,709	42.29	7
8	Rehab/Therapy Aides	7,176	7,893	222,791	28.23	8
9	Activity Director	6,365	7,021	85,226	12.14	9
10	Activity Assistants					10
11	Social Service Workers	3,587	3,957	86,868	21.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,062	19,922	231,791	11.63	15
16	Dishwashers					16
17	Maintenance Workers	3,227	3,563	70,121	19.68	17
18	Housekeepers	6,947	7,661	82,256	10.74	18
19	Laundry	4,528	4,996	51,107	10.23	19
20	Administrator	1,342	1,342	60,849	45.34	20
21	Assistant Administrator	441	441	11,658	26.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,887	7,576	172,100	22.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,605	1,772	34,098	19.24	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,658	1,832	17,472	9.54	33
34	TOTAL (lines 1 - 33)	152,359	167,826	$ 3,143,319 *	$ 18.73	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	5,922	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,922		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 Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Legner (Jan-May & Aug-Sept)	Administrator	0	$ 12,123
Laurie Read (May-Aug)	Administrator	0	22,692
Stacy Brenton (October-December)	Administrator	0	26,034
Brooke Schueller (Jan.- Apr.)	Asst Administrator	0	11,658
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,507

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 246,630
TOTAL (agree to Schedule V, line 17, col. 3)	$ 246,630
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 56,746
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	4,931
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7,		
therefore, no detail schedule is attached.		
Cari Becker	Consulting fees	100
(above consultant fees were reclassed to line 21, therefore, no invoice is attached.)		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 61,777

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,063
Unemployment Compensation Insurance	38,690
FICA Taxes	218,220
Employee Health Insurance	166,870
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	20,121
Appreciation, Oth Benefits & Mktg Adj	7,506
Employee Vac	730
Smsp Match	51
Employee Uniforms	2,010
Home Office Allocation	22,513
TOTAL (agree to Schedule V, line 22, col.8)	$ 497,774

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	14,364
Health Care Worker Background Check	3,395
(Indicate # of checks performed 184)	
Patient Background Checks 212	2,120
Dues & Subscriptions	1,185
Association Dues	5,894
Advertising	31,098
Other Licenses and Permits	573
Less: Non-Allowable Association Dues	(1,678)
Less: Public Relations Expense	( )
Non-allowable advertising	(31,098)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,833

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,362
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)	$ 10,362

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Henry # 0049452 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $2836 & AHCA $1380**

(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. $ **27,363** 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. $ **174,778**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,793**

(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