FOR BHF USE

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

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

I. IDPH License ID Number: 0049536

Facility Name: Heartland of Normal

Address: 510 Broadway (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 452-4406 **Fax #** (309) 454-7908

HFS ID Number:

Date of Initial License for Current Owners: 11/01/81

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 06/01/16 to 05/31/17 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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	116	Skilled (SNF)	116	42,340	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	116	TOTALS	116	42,340	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	13,670	5,479	9,659	28,808	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,670	5,479	9,659	28,808	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.04%

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 11/01/81

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 116 and days of care provided 4,594

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	250,702	24,395	49,744	324,841		324,841		324,841			1
2	Food Purchase		241,394		241,394		241,394	(3)	241,391			2
3	Housekeeping	176,014	29,517	7,392	212,923		212,923		212,923			3
4	Laundry	22,211	14,327	809	37,347		37,347		37,347			4
5	Heat and Other Utilities			140,323	140,323	1,460	141,783		141,783			5
6	Maintenance	50,137	32,443	84,490	167,070		167,070		167,070			6
7	Other (specify):* Medical Waste			8,246	8,246		8,246		8,246			7
8	TOTAL General Services	499,064	342,076	291,004	1,132,144	1,460	1,133,604	(3)	1,133,601			8
	B. Health Care and Programs											
9	Medical Director			24,960	24,960		24,960		24,960			9
10	Nursing and Medical Records	2,113,901	203,426	77,991	2,395,318	35	2,395,353		2,395,353			10
10a	Therapy	774,250	15,497	26,181	815,928		815,928		815,928			10a
11	Activities	71,140	5,859	6	77,005		77,005		77,005			11
12	Social Services	164,218	165	3,107	167,490		167,490		167,490			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,123,509	224,947	132,245	3,480,701	35	3,480,736		3,480,736			16
	C. General Administration											
17	Administrative	119,167		454,180	573,347	(237,194)	336,153		336,153			17
18	Directors Fees											18
19	Professional Services			63,446	63,446		63,446	(63,446)				19
20	Dues, Fees, Subscriptions & Promotions			96,029	96,029		96,029	(49,492)	46,537			20
21	Clerical & General Office Expenses	327,383	57,432	340,192	725,007		725,007	(266,878)	458,129			21
22	Employee Benefits & Payroll Taxes			592,063	592,063	29,116	621,179		621,179			22
23	Inservice Training & Education			2,477	2,477		2,477		2,477			23
24	Travel and Seminar			9,766	9,766		9,766		9,766			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			286,068	286,068		286,068		286,068			26
27	Other (specify):*							(14)	(14)			27
28	TOTAL General Administration	446,550	57,432	1,844,221	2,348,203	(208,078)	2,140,125	(379,830)	1,760,295			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,069,123	624,455	2,267,470	6,961,048	(206,583)	6,754,465	(379,833)	6,374,632			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 Normal #0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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			119,596	119,596	11,194	130,790		130,790			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			852,077	852,077	195,389	1,047,466	(856,665)	190,801			32
33	Real Estate Taxes			78,448	78,448		78,448		78,448			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			79,877	79,877		79,877		79,877			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,129,998	1,129,998	206,583	1,336,581	(856,665)	479,916			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		325,970		325,970		325,970		325,970			39
40	Barber and Beauty Shops			6,305	6,305		6,305		6,305			40
41	Coffee and Gift Shops	46,622			46,622		46,622		46,622			41
42	Provider Participation Fee			204,760	204,760		204,760		204,760			42
43	Other (specify):* IV | X-Ray & Lab		84,331	77,311	161,642		161,642		161,642			43
44	**TOTAL Special Cost Centers**	46,622	410,301	288,376	745,299		745,299		745,299			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,115,745	1,034,756	3,685,844	8,836,345		8,836,345	(1,236,498)	7,599,847			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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 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	(3)	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	(319)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(227)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(14)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(527)	21		18
19	Entertainment				19
20	Contributions	(1,708)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(49,412)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(263,219)	21		24
25	Fund Raising, Advertising and Promotional	(49,492)	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	(871,577)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,236,498)		$	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))**	$ (1,236,498)		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 Normal

ID# 0049536

Report Period Beginning: 06/01/16

Ending: 05/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$ 0	11	1
2	Misc. Income	(300)	21	2
3	Vending Income	(578)	21	3
4	Donations Revenue	0	21	4
5	Accouning/Collection Fees	(14,034)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(856,665)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(871,577)		49

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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
				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	$ 454,180	HCR Manor Care Services, LLC	100.00%	$ 454,180	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	4,115,745	Heartland Employment Services, LLC	100.00%	4,115,745		4
5	V	10a	Therapy Management	13,303	Heartland Rehabilitation Services, LLC	100.00%	13,303		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			$ 4,583,228			$ 4,583,228	$ *	14

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8								8
9			Heartland of Paxton IL, LLC	Paxton				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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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			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
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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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	3,762,500,577	561 nfS, hhS, &	$ 619,847	$ 0	8,862,710	$ 1,460	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	0	0	8,862,710	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs	0	0	8,862,710	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	14,966	9,743	8,862,710	35	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	0	0	8,862,710	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs	0	0	8,862,710	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	61,861,920	32,341,614	8,862,710	145,718	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	14,679,699	5,396,995	8,862,710	39,498	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs	2,741,751	0	8,862,710	31,770	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	5,141,603	0	8,862,710	12,111	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	6,319,907	0	8,862,710	17,005	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	764,848,030	75 NFs	0	0	8,862,710	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,762,500,577	561 nfS, hhS, & Reh	3,929,156	0	8,862,710	9,255	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,293,915,113	359 NFs	720,726	0	8,862,710	1,939	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	764,848,030	75 NFs	0	0	8,862,710	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,762,500,577		30,527,148		8,862,710	71,908	22
23	32	Directly Assigned Interest	Not Allocated			18,393,998			123,481	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				31,980,611				24
25	TOTALS					$ 176,931,332	$ 37,748,352		$ 454,180	25

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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				$ 1,668,364	$ 1,564,014		0.0790	$ 123,481	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										71,908	6
7	Interest Income / Interest Expense										(4,588)	7
8												8
9	TOTAL Facility Related						$ 1,668,364	$ 1,564,014			$ 190,801	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,668,364	$ 1,564,014			$ 190,801	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 Normal # 0049536 **Report Period Beginning:** 06/01/16 **Ending:** 05/31/17

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.**	$	69,176	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.)	$	76,517	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,341	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	71,106	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.	$	78,447	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	71,622	8
	2013	74,078	9
	2014	74,532	10
	2015	74,998	11
	2016	77,570	12

Line 2: $76,517.44 = $37,732.38 for 2nd half 2015 + $38,785.06 for 1st half 2016

Line 4: $71,105.89= $38,785.06 for 2nd half 2016 + $32,320.83 for Jan - May 2017

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 Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0049536

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.	14-28-479-009	See Attached	$ 77,570.12	$ 77,570.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,570.12	$ 77,570.12

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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,829 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		1971	$ 58,339	1
2			1993 & 2001	130,541	2
3	TOTALS			$ 188,880	3

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	90		1971	1962	$ 506,817	$ 16,028		$ 16,028	$	$ 1,306,544	4
5	9			1994	497,564						5
6	10			2001	533,510						6
7	7			2006	480,167						7
8				2010	233,277						8
	Improvement Type**										
9	Current Year Depreciation					44,317		44,317		3,166,064	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18	RETIREMENTS			1987	(29,830)						18
19				1988	207,264						19
20				1989	134,621						20
21				1990	46,332						21
22				1991	15,386						22
23				1992	57,357						23
24	RETIREMENTS			1992	(3,110)						24
25				1993	44,829						25
26				1994	137,130						26
27				1995	72,481						27
28	RENOVATIONS-PATIENT ROOMS			1996	22,684						28
29	CARPET/TILE & INSTALLATION			1996	4,392						29
30	CAPITALIZED LABOR			1996	7,272						30
31	CR5/31/99 AUDIT ADJ - CAPITAL			1996	(7,272)						31
32	WALLVINYL/DRYWALL			1996	5,194						32
33	SIGNS/BOARDS			1996	1,730						33
34	INSTALL GRID/PANELS			1996	4,402						34
35	CONCRETE WALK/RAMP			1996	2,850						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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	CABINETS	1996	$ 1,087	$		$	$	$	37
38	CARPETING	1996	9,845						38
39	ROOFING	1996	24,474						39
40	ELECTRICAL/LIGHTING	1996	2,159						40
41	WALLCOVERINGS	1996	5,910						41
42	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						42
43	INSTALL SHOWER TILE	1996	2,656						43
44	REPAIR COMPRESSOR	1996	900						44
45	CONCRETE WALK	1996	1,053						45
46	PAINTING & DECORATING	1997	15,688						46
47	ROOF REPLACEMENT	1997	3,345						47
48	WALLCOVERINGS	1997	1,788						48
49	TILE & INSTALLATION	1997	2,686						49
50	CARPET	1997	1,547						50
51	INSTALL COMPRESSOR	1997	2,583						51
52	ROOF WORK	1997	51,370						52
53	WALK-IN COOLER/FREEZER	1997	9,466						53
54	ALLOC. FAC. PLAN	1997	2,758						54
55	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)						55
56	PLUMBING/BATHROOM WORK	1997	1,226						56
57	ELECTRICAL	1997	2,416						57
58	FINISH/STUD	1998	4,865						58
59	PAINTING/WALLCOVERINGS	1998	8,175						59
60	CARPETING	1998	6,460						60
61	PLUMBING	1998	1,456						61
62	ROOFING	1998	2,170						62
63	DOORS/WINDOWS/CASEWORK	1998	9,884						63
64	ELECTRICAL	1998	5,360						64
65	FLOORING/CEILING/COVE BASE	1998	13,283						65
66	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						66
67	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702						67
68	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,724,503	$ 60,345		$ 60,345	$	$ 4,472,608	70

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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		$ 3,724,503	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	FURNISH & INSTALL STEEL DOORS	1998	2,439						2
3	MILLWORK	1998	1,166						3
4	INSTALL DUCTS	1998	327						4
5	REWORK FIRE/SMOKE DAMPERS	1998	632						5
6	RENOVATE PATIENT ROOMS	1998	5,233						6
7	WALKWAY	1998	7,267						7
8	ELECTRICAL	1998	8,111						8
9	ROOFING	1998	8,485						9
10	SIGNAGE	1998	13,529						10
11	DOORS/WINDOWS	1998	1,773						11
12	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						12
13	MASONRY	1998	3,700						13
14	PAINTING/WALLCOVER	1998	251						14
15	FLOORING	1998	458						15
16	RENOVATE PATIENT ROOMS	1998	(2,520)						16
17	7/1/06 Capital Rate Adj	1998	2,520						17
18	GAZEBO	1998	2,495						18
19	7/1/06 Capital Rate Adj #2	1998	(2,495)						19
20	FLOORS	1999	2,990						20
21	DOORS	1999	18,097						21
22	FENCING	1999	4,343						22
23	SIDEWALK	1999	3,719						23
24	FIRE SPRINKLER	1999	6,270						24
25	WATER HEATER	1999	7,717						25
26	DOORS (adj yr per Capital Rate Adj #3)	1999	11,081						26
27	PAINTING (adj yr per Capital Rate Adj #4)	1999	28,868						27
28	FLOORS	2000	830						28
29	RENOVATION-ARCADIA ADDTN	2000	5,000						29
30	CONCRETE	2000	1,685						30
31	CARPENTRY	2000	3,179						31
32	DRYWALL/FINISHES	2000	15,397						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,889,557	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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		$ 3,889,557	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	CEILING / FLOORING	2000	5,680						2
3	CAREPTING & PADS	2000	7,167						3
4	WALLCOVERING	2000	7,060						4
5	ELECTRICAL	2000	12,505						5
6	GENERAL OVERHEAD & MISC-ARCADIA ADDTN	2000	25,528						6
7	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(25,528)						7
8	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						8
9	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(5,447)						9
10	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						10
11	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(43,193)						11
12	WATER HEATER	2001	9,350						12
13	8 REPLACEMENT WINDOWS	2001	5,812						13
14	MIXING VALVE	2001	3,397						14
15	CARPET & VWC	2001	24,531						15
16	7/1/06 Capital Rate Adj #5	2001	(21,937)						16
17	SOIL & CONCRETE TESTING	2001	2,905						17
18	WATER & SEWER, PERMIT FEES	2001	14,582						18
19	7/1/06 Capital Rate Adj #6	2001	(13,611)						19
20	SITEWORK	2001	74,254						20
21	7/1/06 Capital Rate Adj #7	2001	(74,254)						21
22	LANDSCAPING	2001	2,270						22
23	ADDITIONAL COST SITEWORK	2001	371						23
24	7/1/06 Capital Rate Adj #8	2001	(371)						24
25	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #9)	2001	10,290						25
26	FRONT HALL & OFFICE WALLS / FLOORS (Cap Adj #10)	2001	8,731						26
27	FRONT HALL & OFFICE WALLS / FLOORS	2002	29,012						27
28	FRONT HALL & OFFICE WALLS / FLOORS	2002	4,580						28
29	FLOORING BY GREASE TRAP	2002	753						29
30	FLOORING	2002	5,415						30
31	ADDITIONAL ARCHITECTURE ENG.	2002	65						31
32	ARCHITECTURE ENGINEERING	2002	350						32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,008,464	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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		$ 4,008,464	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	ARCHITECTURE ENGINEERING	2002	2,993						2
3	DIETARY HVAC	2002	82,214						3
4	7/1/06 Capital Rate Adj #11	2002	(21,512)						4
5	FRONT HALL & OFFICE WALLS/FLOORS	2002	7,395						5
6	7/1/06 Capital Rate Adj #12	2002	(7,395)						6
7	SMOKE SHELTER	2002	3,540						7
8	ALUMINUM SHELTER	2002	5,225						8
9	SIDEWALK	2002	2,375						9
10	FENCE	2002	975						10
11	RETROACTIVE ADDITION	2002	(10)						11
12	7/1/06 Capital Rate Adj	2002	10						12
13	LANDSCAPING	2003	7,887						13
14	DEVELOPERS COST - OVERHEAD	2003	10,184						14
15	7/1/06 Capital Rate Adj #13	2003	(10,184)						15
16	INTEREST ON CONSTRUCTION	2003	722						16
17	7/1/06 Capital Rate Adj #14	2003	(722)						17
18	CARPENTRY	2003	3,460						18
19	FLOORING	2003	7,040						19
20	PAINTING	2003	33,211						20
21	WALLCOVERING	2003	6,434						21
22	HVAC	2003	3,587						22
23	VWC	2003	754						23
24	HANDRAILS & INSTALLATION	2003	2,300						24
25	VWC	2004	922						25
26	BORDER	2004	56						26
27	PAINT, VWC & BORDER	2004	1,300						27
28	CABINETS AND COUNTERTOPS	2004	5,671						28
29	FLOORING	2004	2,288						29
30	FLOORING	2004	7,170						30
31	PAINT & VWC	2004	7,200						31
32	CARPET	2004	868						32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,174,422	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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		$ 4,174,422	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	OVERLAY ASPHALT PARKING LOT	2004	9,662						2
3	PARKING LOT CONSTRUCTION AND PAVING (Cap Adj #15)	2004	55,622						3
4	PAINT & VINYL WALL COVERING	2004	1,189						4
5	PAINT & VINYL WALL COVERING	2004	3,497						5
6	VINYL WALL COVERING	2004	219						6
7	DOOR WITH LOCK	2004	3,461						7
8	EXIT PANEL	2004	1,995						8
9	VINYL COVERED TILE	2004	640						9
10	PAINTING	2004	1,450						10
11	VINYL WALL COVERING	2004	432						11
12	ENGINEERING, OVERHEAD & INTEREST	2004	43,667						12
13	7/1/06 Capital Rate Adj #16	2004	(34,924)						13
14	ELECTRICAL WORK	2004	30,627						14
15	VINYL WALL COVERING	2004	56						15
16	VINYL COVERED TILE AND COVE BASE	2004	2,175						16
17	ADJUST ASSET #1851 (VINYL WALL COVERING)	2004	(56)						17
18	ELECTRICAL WORK	2004	4,342						18
19	ELECTRICAL WORK	2004	8,455						19
20	VINYL WALL COVERING	2004	1,279						20
21	13 PHONE LINES & JACKS	2004	3,520						21
22	ENGINEERING, OVERHEAD & INTEREST	2005	9,557						22
23	7/1/06 Capital Rate Adj #17	2005	(9,557)						23
24	VINYL WALL COVERING	2005	1,279						24
25	7/1/06 Capital Rate Adj #18	2005	(1,279)						25
26	VINYL WALL COVERING	2005	506						26
27	VINYL WALL COVERING	2005	526						27
28	VINYL WALL COVERING	2005	159						28
29	VINYL WALL COVERING	2005	257						29
30	VINYL WALL COVERING	2005	7,268						30
31	VINYL WALL COVERING	2005	2,749						31
32	VINYL WALL COVERING	2005	2,670						32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,325,865	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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		$ 4,325,865	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	VINYL WALL COVERING	2005	2,510						2
3	FLOORING VINYL	2005	1,980						3
4	KICK RAIL	2005	2,354						4
5	WINDOW TREATMENTS	2005	5,098						5
6	VINYL COVERED TILE & CARPET	2005	9,340						6
7	DOOR	2005	1,580						7
8	CEILING TILE	2005	29,500						8
9	OVERHEAD & INTEREST	2005	18,308						9
10	7/1/06 Capital Rate Adj #19	2005	(18,308)						10
11	ROOFING & SHEET METAL	2005	237,310						11
12	DUCT WORK	2005	6,802						12
13	SITE PREP, LANDSCAPING, UTILITIES	2006	52,007						13
14	SOIL & CONCRETE TESTING	2006	2,435						14
15	ELECTRICAL POWER SUPPLY	2006	2,295						15
16	ARCHITECT & ENGINEERING COSTS	2006	85,271						16
17	GENERAL OVERHEAD & INTEREST	2006	46,990						17
18	PLAN REVIEWS	2006	8,192						18
19	WALLCOVERINGS	2006	9,806						19
20	MILLWORK	2006	1,766						20
21	DINING ROOM RAILS	2007	2,950						21
22	DINING ROOM PAINTING	2007	3,950						22
23	ARCHITECT & ENGINEERING COSTS	2007	3,662						23
24	GENERAL OVERHEAD & INTEREST	2007	11,136						24
25	RESILIENT FLOORING	2007	780						25
26	WALLCOVERINGS	2007	17,334						26
27	CARPENTRY	2007	29,147						27
28	DOORS & FRAMES	2007	17,334						28
29	2 ROOF TOP UNITS	2007	4,885						29
30	UTILITY RM IMPROVEMENTS	2007	4,900						30
31	2 ROOF TOP UNITS	2007	6,444						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,933,623	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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		$ 4,933,623	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	000000001982 CARPET	2008	633						2
3	000000001984 NURSE STN, ADMIN OFF, MED RM RENVSTN	2008	22,232						3
4	000000001985 NURSE STATION CABINETRY	2008	17,892						4
5	000000001986 ADJ TO NURSE STATION (#1985)	2008	333						5
6	000000001987 RENOV CORR WALLS AND KITCH CEI	2008	6,850						6
7	000000001988 2 DOOR CLOSURES AND FRAMES	2009	12,974						7
8	000000001989 WALLCOVER PAINT EMPLOYEE HALLW	2009	5,175						8
9									9
10	New Sidewalks	2009	15,500						10
11	Renov. - Interior Demo & Renovations - Corridor Renovation	2009	83,910						11
12	Renov. - Resilent Flooring - Corridor Renovation	2009	14,912						12
13	Renov. - Carpeting & Pads - Corridor Renovation	2009	8,142						13
14	Renov. - Wallcovering & Corner Guards - Corridor Renovation	2009	50,857						14
15	Water Heaters (2) BTH-300A	2009	30,010						15
16	Concrete Flooring & Replace Under Floor Water Line	2009	4,050						16
17	New Copper Water Lines	2010	12,214						17
18	Dining Rm/Therapy-Site Prep, General Contractor	2010	21,798						18
19	Dining Rm/Therapy-Soil Tesing	2010	1,845						19
20	Dining Rm/Therapy-Arch & Engineer Cost	2010	64,025						20
21	Dining Rm/Therapy-Wallcovering	2010	1,864						21
22	Trench Box and New Gas Line	2010	4,043						22
23									23
24	Concrete Pad (main entr)	2010	4,940						24
25	Normal PT Addition - Wiring & Lights	2010	1,473						25
26	Renov. - Fire Doors, 3 sets	2010	38,850						26
27	Renov. - Painting & Wallcovering	2010	6,705						27
28	Addt'l Dining Rm/Therapy-Arch & Engineer Cost	2010	2,138						28
29	Flooring & VWC in shower	2011	18,813						29
30	HM Doors (2)	2011	6,953						30
31									31
32	Rooftop Unit, 3 ton	2011	8,627						32
33	Damper for Laundry Room	2011	2,574						33
34	**TOTAL (lines 1 thru 33)**		$ 5,403,955	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 12G, Carried Forward		$ 5,403,955	$ 60,345		$ 60,345	$	$ 4,472,608	1
2	Water Heater	2011	3,641						2
3	Rooftop Unit, 4 ton, Dining Room	2011	10,295						3
4	Sprinkler System Upgrade	2011	10,175						4
5	Recirculation Pump	2012	4,195						5
6	Lighting - Overbed (all)	2012	21,338						6
7									7
8	80' French Drainage & repair wall	2012	8,984						8
9	AC Control Board	2012	5,009						9
10	Ceiling Tile Replacement 7,200 Sq Ft	2013	32,800						10
11									11
12	Dietary Grease Trap & Tank	2013	10,523						12
13	Hot Water Heaters (3) 120 gallon	2014	42,399						13
14									14
15	Lighted Outdoor Sign 96" x 87"	2014	7,414						15
16	General Electrical Upgrades	2014	18,750						16
17	Engineering cost for new boilers, accessories, pipe modifications	2014	6,900						17
18									18
19	Secure Care door alarm-EE entrance, PT & West Therapy	2016	3,681						19
20	Insulate Condensate Line	2016	2,760						20
21	Water Heater	2017	12,600						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)		$ 5,605,419	$ 60,345		$ 60,345	$	$ 4,472,608	34

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 2,238,668	$ 59,251	$ 59,251	$		$ 2,074,163	71
72	Current Year Purchases	12,539						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			11,194	11,194			74
75	TOTALS	$ 2,251,207	$ 59,251	$ 70,445	$ 11,194		$ 2,074,163	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,045,506	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,596	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,790	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,194	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,546,771	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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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: $ 62,577 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	2014 Dodge Grand Carava	$ 1033	$ 17,300	17
18					18
19				above figure includes	19
20				gas & maintenance too	20
21	TOTAL		$	$ 17,300	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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	4076 hrs	$ 169,341		$	$ 235	4,076	$ 169,576	1
2	Licensed Speech and Language Development Therapist	10a	1165 hrs	48,400			857	1,165	49,257	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4206 hrs	174,727			14,405	4,206	189,132	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				325,970		325,970	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Therapy	43, 2					84,331		84,331	12
13	Other (specify): X-Ray & Lab	43, 3				77,311			77,311	13
14	TOTAL			$ 392,468		$ 77,311	$ 425,798	9,447	$ 895,577	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 Normal **#** 0049536 **Report Period Beginning:** 06/01/16 **Ending:** 05/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/17 **(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	$ 1,869	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 536,560)	1,078,133		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,202		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,093,204	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	188,880		13
14	Buildings, at Historical Cost	5,605,419		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,251,207		16
17	Accumulated Depreciation (book methods)	(6,546,771)		17
18	Deferred Charges	130,483		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	5,773		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,634,991	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,728,195	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 214,359	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	335,605		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	71,106		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	133,499		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 754,569	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,564,014		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)**	$ 1,564,014	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,318,583	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 409,612	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,728,195	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Normal **#** 0049536 **Report Period Beginning:** 06/01/16 **Ending:** 05/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,094,061	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,094,061	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,379,167)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,379,167)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(11,305,282)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (11,305,282)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 409,612	24 *

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

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 7,709,660	1
2	Discounts and Allowances for all Levels	(3,824,211)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,885,449	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,705,507	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,705,507	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	592	12
13	Barber and Beauty Care	5,090	13
14	Non-Patient Meals	3	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	671,306	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,860	19
20	Radiology and X-Ray	28,781	20
21	Other Medical Services	71,373	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 863,005	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Inc, QI paymts & Purch Disc	3,217	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,217	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,457,178	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,132,144	31
32	Health Care	3,480,701	32
33	General Administration	2,348,203	33
	B. Capital Expense		
34	Ownership	1,129,998	34
	C. Ancillary Expense		
35	Special Cost Centers	540,539	35
36	Provider Participation Fee	204,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,836,345	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,379,167)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,379,167)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,852,496	44
45	Private Pay - Net Inpatient Revenue	1,243,146	45
46	Medicare - Net Inpatient Revenue	394,631	46
47	Other-(specify) Hospice	181,151	47
48	Other-(specify) Insurance	214,025	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,885,449	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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	1,631	1,762	$ 71,462	$ 40.56	1
2	Assistant Director of Nursing	5,907	6,380	215,322	33.75	2
3	Registered Nurses	15,713	16,973	477,292	28.12	3
4	Licensed Practical Nurses	19,837	21,428	482,098	22.50	4
5	CNAs & Orderlies	63,185	68,438	832,750	12.17	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,098	13,075	543,164	41.54	7
8	Rehab/Therapy Aides	6,719	7,262	231,086	31.82	8
9	Activity Director	4,732	5,119	71,140	13.90	9
10	Activity Assistants					10
11	Social Service Workers	6,249	6,756	164,218	24.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,858	20,379	250,702	12.30	15
16	Dishwashers					16
17	Maintenance Workers	2,009	2,173	50,137	23.07	17
18	Housekeepers	13,148	14,221	176,014	12.38	18
19	Laundry	2,019	2,186	22,211	10.16	19
20	Administrator	2,080	2,080	117,323	56.41	20
21	Assistant Administrator	117	117	1,844	15.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,261	15,413	327,383	21.24	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	2,074	2,243	34,977	15.59	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	3,285	3,551	46,622	13.13	33
34	TOTAL (lines 1 - 33)	193,922	209,556	$ 4,115,745 *	$ 19.64	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	24,960	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)		$ 24,960		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 Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Douglas M. Rutter	Administrator	0	$ 117,323
Jennifer R. Badgley	Asst. Administrator	0	1,844
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,167

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 454,180
TOTAL (agree to Schedule V, line 17, col. 3)	$ 454,180
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 49,412
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	14,034
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 63,446

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,365
Unemployment Compensation Insurance	52,795
FICA Taxes	292,097
Employee Health Insurance	186,486
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	12,825
Appreciation, Other Benefits & Mktg Adj	
Tuition Program	8,159
Smsp Match	65
Employee Uniforms	9,271
Home Office Allocation	29,116
TOTAL (agree to Schedule V, line 22, col.8)	$ 621,179

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	$ 1,990
Advertising: Employee Recruitment	21,010
Health Care Worker Background Check	
(Indicate # of checks performed 272)	2,383
Patient Background Checks 396	3,960
Dues & Subscriptions	9,008
Association Dues	7,273
Advertising	47,146
Other Licenses and Permits	3,259
Less: Non-Allowable Association Dues	(2,346)
Less: Public Relations Expense	( )
Non-allowable advertising	(47,146)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,537

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,766
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)	$ 9,766

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Normal # 0049536 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 $3,224 & AHCA $1,703**

(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. $ **49,727** 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. $ **204,760**
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**

(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