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: 0049494

Facility Name: Heartland of Paxton

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

County: Ford

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Jeff Lewandowski **Telephone Number:** (419) 252-5736
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 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 Paxton # 0049494 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	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,998	6,637	6,555	21,190	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,998	6,637	6,555	21,190	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.77%

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 10/3/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 106 and days of care provided 4,165

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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	224,253	17,663	5,642	247,558		247,558		247,558			1
2	Food Purchase		175,458		175,458		175,458	(838)	174,620			2
3	Housekeeping	115,224	12,267	4,000	131,491		131,491		131,491			3
4	Laundry	25,262	12,772	304	38,338		38,338		38,338			4
5	Heat and Other Utilities			131,090	131,090	1,166	132,256		132,256			5
6	Maintenance	58,886	24,393	78,049	161,328		161,328		161,328			6
7	Other (specify):* Medical Waste			642	642		642		642			7
8	TOTAL General Services	423,625	242,553	219,727	885,905	1,166	887,071	(838)	886,233			8
	B. Health Care and Programs											
9	Medical Director			23,000	23,000		23,000		23,000			9
10	Nursing and Medical Records	1,790,576	137,726	(12,258)	1,916,044	27	1,916,071		1,916,071			10
10a	Therapy	575,852	5,955	5,709	587,516		587,516		587,516			10a
11	Activities	68,116	6,789	1,888	76,793		76,793		76,793			11
12	Social Services	101,577		6,368	107,945		107,945		107,945			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,536,121	150,470	24,707	2,711,298	27	2,711,325		2,711,325			16
	C. General Administration											
17	Administrative	82,765		274,138	356,903	(120,503)	236,400		236,400			17
18	Directors Fees											18
19	Professional Services			64,174	64,174		64,174	(64,174)				19
20	Dues, Fees, Subscriptions & Promotions			78,387	78,387		78,387	(23,953)	54,434			20
21	Clerical & General Office Expenses	280,518	77,571	264,741	622,830		622,830	(179,985)	442,845			21
22	Employee Benefits & Payroll Taxes			492,924	492,924	21,609	514,533		514,533			22
23	Inservice Training & Education			1,108	1,108		1,108		1,108			23
24	Travel and Seminar			6,406	6,406		6,406		6,406			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,842	54,842		54,842		54,842			26
27	Other (specify):*							(43)	(43)			27
28	TOTAL General Administration	363,283	77,571	1,236,720	1,677,574	(98,894)	1,578,680	(268,155)	1,310,525			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,323,029	470,594	1,481,154	5,274,777	(97,701)	5,177,076	(268,993)	4,908,083			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland of Paxton #0049494 Report Period Beginning: 01/01/17 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			296,192	296,192	7,163	303,355		303,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			333,130	333,130	90,538	423,668	(335,505)	88,163			32
33	Real Estate Taxes			87,104	87,104		87,104		87,104			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			36,483	36,483		36,483		36,483			35
36	Other (specify):*											36
37	**TOTAL Ownership**			752,909	752,909	97,701	850,610	(335,505)	515,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,424	86	156,510		156,510		156,510			39
40	Barber and Beauty Shops		496	7,090	7,586		7,586		7,586			40
41	Coffee and Gift Shops	34,175			34,175		34,175		34,175			41
42	Provider Participation Fee			160,217	160,217		160,217		160,217			42
43	Other (specify):* IV | X-Ray & Lab		11,663	14,939	26,602		26,602		26,602			43
44	**TOTAL Special Cost Centers**	34,175	168,583	182,332	385,090		385,090		385,090			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,357,204	639,177	2,416,395	6,412,776		6,412,776	(604,498)	5,808,278			45

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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 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	(838)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(1,026)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(43)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment				19
20	Contributions	(1,359)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(57,621)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(174,339)	21		24
25	Fund Raising, Advertising and Promotional	(23,953)	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	(343,617)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (604,498)		$	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))**	$ (604,498)		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 Paxton

ID# 0049494

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income		21	2
3	Vending Income	(399)	21	3
4	Donations Revenue	(1,160)	21	4
5	Accouning/Collection Fees	(6,553)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(335,505)	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**	(343,617)		49

Facility Name & ID Number Heartland of Paxton # 0049494 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	$ 274,138	HCR Manor Care Services, LLC	0.00%	$ 274,138	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,357,204	Heartland Employment Services, LLC	0.00%	3,357,204		4
5	V	10a	Therapy Management	14,327	Heartland Rehabilitation Services, LLC	0.00%	14,327		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			$ 3,645,669			$ 3,645,669	$ *	14

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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 Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			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 Paxton # 0049494 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 Paxton # 0049494 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	6,236,098	$ 1,166	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	6,236,098	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	6,236,098	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	16,031	10,238	6,236,098	27	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	6,236,098	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	6,236,098	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	6,236,098	100,052	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	16,450,188	6,362,586	6,236,098	31,610	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	2,602,958	0	6,236,098	21,973	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	5,900,308	0	6,236,098	9,843	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	6,123,085	0	6,236,098	11,766	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	0	0	6,236,098	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	3,462,953	0	6,236,098	5,777	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	721,157	0	6,236,098	1,386	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	6,236,098	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,738,067,390		28,591,078		6,236,098	47,698	22
23	32	Directly Assigned Interest	Not Allocated			16,243,764			42,840	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,016,444				24
25	TOTALS					$ 174,800,956	$ 39,240,058		$ 274,138	25

Facility Name & ID Number Heartland of Paxton # 0049494 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				$ 618,583	$ 553,559		0.0774	$ 42,840	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										47,698	6
7	Interest Income / Interest Expense										(2,375)	7
8												8
9	TOTAL Facility Related						$ 618,583	$ 553,559			$ 88,163	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 618,583	$ 553,559			$ 88,163	15

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

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

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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.**	$ 79,727	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.)		$ 83,416	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,689	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 83,416	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.		$ 87,105	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	73,439	8
	2013	76,118	9
	2014	77,350	10
	2015	79,727	11
	2016	83,416	12

Line 2: $83,415.66 = $41,707.83 for 2nd half 2015 + $41,707.83 for 1st half 2016

Line 4: Same 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 Paxton COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0049494

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

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

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

Enter the tax index number and real estate tax assessed for 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.	11-14-08-476-001	See Attached	$ 83,415.66	$ 83,415.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,415.66	$ 83,415.66

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 Paxton # 0049494 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,285 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

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

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

Facility Name & ID Number Heartland of Paxton # 0049494 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	96		1988	1988	$ 1,323,187	$ 157,270		$ 157,270	$	$ 3,098,547	4
5	Audit Adj#1- Overhd & Int(year 1998) & Aud Adj #2 Various(year 2001)				1,536,322						5
6				2004	673,649						6
7				2008	649,952						7
8	10			2009	558,648						8
	Improvement Type**										
9	Current Year Depreciation					73,929		73,929		1,936,269	9
10	Land/Bldg. Improvement (See attached schedule)			1988	279,229						10
11	Additional Attic Insulation			1989	3,500						11
12	Fire Alarm System			1990	294						12
13	Audit Adj (#3) - Fire Alarm System			1990	(294)						13
14	Land/Bldg. Improvement (See attached schedule)			1990	8,348						14
15	Land/Bldg. Improvement (See attached schedule)			1991	6,404						15
16	Land/Bldg. Improvement (See attached schedule)			1992	24,904						16
17	Land/Bldg. Improvement (See attached schedule)			1993	12,778						17
18	Land/Bldg. Improvement (See attached schedule)			1994	1,010						18
19	Land/Bldg. Improvement (See attached schedule)			1995	14,522						19
20	BATHTUB			1996	356						20
21	(7) DOORS			1996	3,896						21
22	WALLCOVERING			1996	1,133						22
23	CARPET & WALLCOVERING			1996	2,199						23
24	CEILING			1997	2,101						24
25	WALLCOVERING			1997	8,139						25
26	WALLCOVERING			1997	22						26
27	CREDIT ON BLD IMP-CNCLD RETAIN			1997	(434)						27
28	WALLCOVERING			1997	13,695						28
29	CARPET			1997	1,081						29
30	WALLCOVERING			1997	1,571						30
31	ENGINEERING AND ARCHITECTURAL FEES			1997	75,055						31
32	Audit Adj (#4) - Various			1997	(22,168)						32
33	(14) PKG AMANA A/C UNITS			1997	9,051						33
34	PAINTING			1997	10,933						34
35	PAINTING & WALLCOVERING			1997	7,933						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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	NURSE CALL SYSTEM	1997	$ 2,561	$		$	$	$	37
38	VINYL WALL COVERING FROM INVENTORY	1997	293						38
39	VINYL WALL COVERING FROM INVENTORY	1997	187						39
40	VINYL WALL COVERING FROM INVENTORY	1997	814						40
41	CUBICLE CURTAIN TRACK	1997	1,416						41
42	NURSE CALL SYSTEM UPGRADE	1997	2,305						42
43	WALLCOVERING	1997	157						43
44	CROWN MOLDING & CHAIR RAIL	1997	820						44
45	GARAGE WOOD	1997	12,983						45
46	ADDL'T COST FOR NURSE CALL SYSTEM #15	1998	167						46
47	WALLCOVERING	1998	191						47
48	COVE BASE	1998	1,529						48
49	WALLCOVERING	1998	75						49
50	DOOR ALARMS	1998	3,598						50
51	WALLCOVERING	1998	249						51
52	SECURE CARE LOCKS	1998	11,971						52
53	ADDL'T NURSE CALL SYSTEM	1998	1,901						53
54	WALLPAPER FROM CONSTRUCTION	1998	196						54
55	GATE	1998	390						55
56	A/C UNIT	1998	1,925						56
57	HVAC FOR ADDITION	1998	47,008						57
58	AUDIT ADJ (#5) - VARIOUS	1998	(6,158)						58
59	BRASH BARRY GENERAL CONSTRUCTION	1998	23,132						59
60	REMOVE OVERHEAD PAGING	1998	338						60
61	WALLCOVERING	1998	7,678						61
62	CABINETRY & COUTNERTOPS	1998	8,240						62
63	CARPENTRY	1998	24,126						63
64	ELECTRICAL WORK	1998	444						64
65	ELECTRICAL WORK	1998	32,894						65
66	LIGHT FIXTURES	1998	1,253						66
67	PLUMBING WORK	1998	711						67
68	LAWNCARE SEEDED CONSTRUCTION AREA	1998	440						68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,390,850	$ 231,199		$ 231,199	$	$ 5,034,816	70

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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		$ 5,390,850	$ 231,199		$ 231,199	$	$ 5,034,816	1
2	SPRINKLER SYSTEM	1998	45,812						2
3	FIRE ALARM SYSTEM	1998	3,370						3
4	FENCE	1998	6,507						4
5	PAVING	1998	38,079						5
6	CONSTRUCTION AND DESIGN OVERHEAD COST	1999	114,792						6
7	AUDIT ADJ (#6) - OVERHEAD COST	1999	(114,792)						7
8	DIRECT VENT UNIT HEATER	1999	1,556						8
9	SECURE CARE LOCKING SYSTEM	1999	958						9
10	SEAL & STRIPE PARKING LOT	1999	3,136						10
11	EXTERIOR LIGHTING	1999	20,250						11
12	SINK & FAUCET	2000	596						12
13	NURSES STATION	2000	11,790						13
14	COUNTERTOP	2000	1,200						14
15	VCT	2000	1,140						15
16	WATER HEATER	2000	3,780						16
17	NURSES STATION	2000	475						17
18	PAINTING	2000	11,005						18
19	CUSTOM CABINETS	2000	7,091						19
20	INSTALL CARPET	2001	593						20
21	GAZEBO	2001	4,319						21
22	CARPENTRY-ARCADIA RENOV	2001	16,430						22
23	CARPENTRY-ARCADIA RENOV	2001	13,084						23
24	AUDIT ADJ (#7) - CARPENTRY	2001	(1,469)						24
25	LANDSCAPING-ARCADIA RENOV	2002	21,295						25
26	AUDIT ADJ (#2) - TRANSFER TO BUILDING	2002	(21,295)						26
27	PAINTING	2002	7,175						27
28	PAINTING	2002	825						28
29	DRAPES	2002	130						29
30	FLOORING,VINYL WALL COVERING	2002	8,405						30
31	OUTDOOR LIGHTING	2002	1,560						31
32	DOORS	2002	5,900						32
33	HALLWAY PAINT AND BORDER	2002	1,150						33
34	TOTAL (lines 1 thru 33)		$ 5,605,697	$ 231,199		$ 231,199	$	$ 5,034,816	34

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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		$ 5,605,697	$ 231,199		$ 231,199	$	$ 5,034,816	1
2	MDS OFFICE-VINYL WALL COVERING	2003	419						2
3	AUDIT ADJ (#9) - VWC	2003	(25)						3
4	MDS OFFICE-PAINTING & VINYL WALL COVERING	2003	945						4
5	MDS OFFICE-RETAINAGE-PAINTING & VWC	2003	105						5
6	MDS OFFICE-ELECTRIC WORK	2003	1,338						6
7	MDS OFFICE-BORDER	2003	66						7
8	AUDIT ADJ (#10) - BORDER	2003	(4)						8
9	CARPET	2003	1,051						9
10	SNF ADDITION-ARCHITECT COSTS	2003	4,612						10
11	OUTLETS IN DINING ROOM	2003	1,280						11
12	TESTING GEOTECHNICAL	2003	3,519						12
13	ENGINEERING, ARCHITECTURAL FEES	2003	156,819						13
14	7/1/06 CAPITAL RATE ADJUST #3	2003	(63,267)						14
15	RESILIENT FLOORING	2004	17,087						15
16	7/1/06 CAPITAL RATE ADJUST #1	2004	(137)						16
17	SECURITY DOOR	2004	5,354						17
18	WATER,SEWER,UTILITIES FOR ADDITION	2004	44,792						18
19	7/1/06 CAPITAL RATE ADJUST #2	2004	(44,792)						19
20	VINYL WALL COVERING, FLOORING	2004	12,441						20
21	VINYL WALL COVERING, FLOORING (ADJUSTMENT)	2004	(75)						21
22	MILLWORK	2004	2,815						22
23	NEW ROOF	2004	88,184						23
24	SECURITY DOOR	2005	4,932						24
25	CONCRETE WALK & PAD	2006	558						25
26	5 PTAC UNITS	2006	4,136						26
27	CUSTOM WORKSTATIONS	2006	1,806						27
28	DINING,LOBBY,OFFICE-GENL O/H	2007	6,606						28
29	DINING-CARPENTRY	2007	38,528						29
30	ADMISSIONS-CARPENTRY	2007	10,290						30
31	DINING-WALLCOVERING	2007	3,595						31
32	LOBBY-WALLCOVERING	2007	2,288						32
33	ADMINISTRATOR-WALLCOVERING	2007	855						33
34	TOTAL (lines 1 thru 33)		$ 5,911,818	$ 231,199		$ 231,199	$	$ 5,034,816	34

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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		$ 5,911,818	$ 231,199		$ 231,199	$	$ 5,034,816	1
2	ADMISSIONS-WALLCOVERING	2007	823						2
3	DINING,LOBBY,OFFICE-INTEREST	2007	486						3
4	CEILING	2007	14,580						4
5	CONF RM BIRD LOUNGE	2006	2,228						5
6	PAXTON PT - GEN'L CONTRACTOR	2008	980						6
7	PAXTON PT - LANDSCAPING	2008	11,376						7
8	PAXTON PT - CONCRETE TESTING	2008	1,478						8
9	PAXTON PT -SOIL TESTING	2008	2,175						9
10	PAXTON PT - ARCH & ENGINEER COST	2008	63,523						10
11	PAXTON PT - GENERAL OVERHEAD CAPITAL	2008	236,698						11
12	PAXTON PT - PLAN REVIEWS	2008	6,000						12
13	PAXTON PT - INTEREST ON CONSTRUCTION	2008	37,527						13
14	PAXTON PT - ELECTRICAL	2008	110						14
15	PAXTON PT - CARPETING & PADS	2008	1,770						15
16	PAXTON PT - WALL COVERING	2008	394						16
17									17
18	000000050576 Ren-Gen ovhd capit	2009	33,063						18
19	000000050576 Renovation-interest on const	2009	1,169						19
20	000000050579 Renovation -Carpentry	2009	91,141						20
21	000000050580 Ren-lobby finishes	2009	3,520						21
22	000000050580 Ren-carpeting & pads	2009	12,110						22
23	000000050580 Ren-wallcovering	2009	14,890						23
24	50582 PAX ADD-Architect & Eng Cost	2009	85,342						24
25	50584 PAX ADD-General Overhead Capital	2009	10,719						25
26	50588 PAX ADD-interest on construction	2009	4,129						26
27	50589 PAX ADD-millwork	2009	4,815						27
28	50590 PAX ADD-wall cov, cubicle track & corn guards	2009	9,608						28
29	LI-50583 PAX ADD-Soil & concrete testing	2009	3,936						29
30	LI-50591 PAX ADD-Gen Contractor-sitework	2009	54,829						30
31									31
32	BI 50582 PAXTON ADD-architect & eng cost	2009	1,078						32
33	BI 50614 Flooring	2010	11,415						33
34	TOTAL (lines 1 thru 33)		$ 6,633,730	$ 231,199		$ 231,199	$	$ 5,034,816	34

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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		$ 6,633,730	$ 231,199		$ 231,199	$	$ 5,034,816	1
2	BI 050625 ceramic flooring, walls s	2011	13,666						2
3	BI 050645 SEALCOAT & STRIPPING OF P	2011	6,738						3
4	BI 050646 HOT WATER HEATER	2011	5,301						4
5	000000050657 SIDEWALK REPLACEMENTS	2012	4,328						5
6	000000050660 CABINETS (DOCTOR'S OFFICE	2012	4,899						6
7	000000050666 WATER HEATER	2012	11,475						7
8									8
9	50670 INSTALL DIN RM FURNACE IN MECH RM	2013	3,625						9
10	50675 WINDOW FIRE SHUTTER	2013	3,356						10
11	50679 INSTALL KITCHEN FIRE WINDOW	2013	300						11
12									12
13	50688 Electrical Breaker Panel	2014	1,645						13
14	50695 wallcovering for therapy room expansion	2014	1,190						14
15	50696 Carpentry for therapy room expansion	2014	43,023						15
16	50697 Architect & Eng cost-therapy room expansion	2014	18,918						16
17	50712 Paving in two areas	2014	19,665						17
18	50714 A#50697 Architech & Engineer cost adj	2014	1,650						18
19									19
20	50717 HVAC change for fire sprinklers	2014	6,732						20
21	50818 ARCHITECT fees for fire spnklrs/HVAC	2014	1,341						21
22	50735 TILE FLOOR-res room	2015	1,346						22
23	50736 Paint & WALLCOVERING-reception area	2015	5,000						23
24	50738 Paint & WALLCOVERING-reception area	2015	15,336						24
25									25
26	50742 Backflow preventer-west wall in fire pump mechanical roon	2016	3,579						26
27	50743 Materials and work for Facility fire alarm system	2016	6,400						27
28	50748 Install life safety panel	2016	3,600						28
29	50752 Install CR Panel - NFPA Generator Corrections	2016	24,000						29
30	50762 Water Softner replacement	2016	13,925						30
31	50765 Access control system - entrance doors/east dining ext doors	2016	23,272						31
32	50767 Replace Water Heaters for Kitchen Area	2016	13,249						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,891,289	$ 231,199		$ 231,199	$	$ 5,034,816	34

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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		$ 6,891,289	$ 231,199		$ 231,199	$	$ 5,034,816	1
2	50774 External Metal Doors for (2) Break Room & 100 Hall	2017	5,789						2
3	50779 Door closer/hold open, rms 113 and 707	2017	2,630						3
4	50780 Sprinkler Heads (5) for front canopy	2016	2,384						4
5	50781/6 Carpet in Social Service Office, Paint and flooring in publ	2017	3,745						5
6	50787 Installed smoke walls (3)/3M firestop materials on 1st floor l	2017	2,708						6
7	50789 Water heater, 100 gallon w/thermal expansion tank in mech	2016	6,890						7
8	50791 Exterior door & frame w/sidelight by room 119	2017	6,850						8
9	50794 Wallguard system model 1500 for main hallway	2017	3,252						9
10	50802 Parking lot paving	2017	15,520						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	TOTAL (lines 1 thru 33)		$ 6,941,057	$ 231,199		$ 231,199	$	$ 5,034,816	34

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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	$ 2,156,952	$ 64,993	$ 64,993	$		$ 2,006,755	71
72	Current Year Purchases	8,660						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			7,163	7,163			74
75	TOTALS	$ 2,165,612	$ 64,993	$ 72,156	$ 7,163		$ 2,006,755	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,181,855	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,192	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 303,355	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,163	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,041,571	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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:				$			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: $ 18,585 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	2017 Ford T150 Transit V	$	$ 17,898	17
18					18
19				above figure includes	19
20				gas & maintenance	20
21	TOTAL		$	$ 17,898	21

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

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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	2133 hrs	$ 86,366		$	$ 282	2,133	$ 86,648	1
2	Licensed Speech and Language Development Therapist	10a	1612 hrs	65,291			40	1,612	65,331	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4059 hrs	164,400			5,633	4,059	170,033	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				156,424		156,424	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3								12
13	Other (specify): X-Ray & Lab | IV	43, 3 & 2				14,939	11,663		26,602	13
14	TOTAL			$ 316,057		$ 14,939	$ 174,042	7,804	$ 505,038	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heartland of Paxton **#** 0049494 **Report Period Beginning:** 01/01/17 **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	$ 14,182	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (199,369))	639,726		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,888		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 665,796	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,186		13
14	Buildings, at Historical Cost	6,941,057		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,165,612		16
17	Accumulated Depreciation (book methods)	(7,041,571)		17
18	Deferred Charges	107,986		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe OMIT	51,184		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,299,454	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,965,250	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 136,533	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,601		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,416		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	63,075		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 566,625	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	553,559		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)**	$ 553,559	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,120,184	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,845,066	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,965,250	$	48

***(See instructions.)**

Facility Name & ID Number Heartland of Paxton # 0049494 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**	$ 1,887,701	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,887,701	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(647,358)	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)**	$ (647,358)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	604,723	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 604,723	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,845,066	24 *

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

Facility Name & ID Number Heartland of Paxton # 0049494 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	$ 5,816,553	1
2	Discounts and Allowances for all Levels	(2,226,227)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,590,326	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,715,173	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,715,173	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	442	12
13	Barber and Beauty Care	7,307	13
14	Non-Patient Meals	838	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	297,323	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,261	19
20	Radiology and X-Ray	21,474	20
21	Other Medical Services	111,088	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 457,733	23
	D. Non-Operating Revenue		
24	Contributions	1,160	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,160	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,026	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,026	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,765,418	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	885,905	31
32	Health Care	2,711,298	32
33	General Administration	1,677,574	33
	B. Capital Expense		
34	Ownership	752,909	34
	C. Ancillary Expense		
35	Special Cost Centers	224,873	35
36	Provider Participation Fee	160,217	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,412,776	40
41	**Income before Income Taxes (line 30 minus line 40)****	(647,358)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (647,358)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,063,234	44
45	Private Pay - Net Inpatient Revenue	1,564,051	45
46	Medicare - Net Inpatient Revenue	718,726	46
47	Other-(specify) Hospice	164,351	47
48	Other-(specify) Insurance	79,964	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,590,326	49

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

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

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

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 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	1,520	1,677	$ 65,145	$ 38.85	1
2	Assistant Director of Nursing	3,092	3,412	110,681	32.44	2
3	Registered Nurses	12,615	13,919	418,181	30.04	3
4	Licensed Practical Nurses	18,235	20,120	495,763	24.64	4
5	CNAs & Orderlies	45,678	50,399	677,141	13.44	5
6	CNA Trainees					6
7	Licensed Therapist	9,975	10,975	444,455	40.50	7
8	Rehab/Therapy Aides	3,541	3,895	131,397	33.73	8
9	Activity Director	4,388	4,835	68,116	14.09	9
10	Activity Assistants					10
11	Social Service Workers	4,977	5,493	101,577	18.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,489	18,190	224,253	12.33	15
16	Dishwashers					16
17	Maintenance Workers	2,260	2,492	58,886	23.63	17
18	Housekeepers	9,202	10,146	115,224	11.36	18
19	Laundry	2,206	2,434	25,262	10.38	19
20	Administrator	2,080	2,080	82,765	39.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,949	14,351	280,518	19.55	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	1,573	1,734	23,665	13.65	31
32	Other Health Care(specify)					32
33	Other(specify)	2,042	2,252	34,175	15.18	33
34	TOTAL (lines 1 - 33)	152,822	168,404	$ 3,357,204 *	$ 19.94	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	23,000	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)		$ 23,000		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heartland of Paxton # 0049494 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donna Kinkade	Administrator	0	$ 89,350
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 89,350

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 274,138
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 274,138

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 57,621
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	6,553
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)		$ 64,174

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,188
Unemployment Compensation Insurance	39,670
FICA Taxes	238,990
Employee Health Insurance	145,681
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	16,760
Appreciation, Oth Benefits & Mktg Adj	14,884
Tuition Program	(500)
Smsp Match	281
Employee Uniforms	7,970
Home Office Allocation	21,609
TOTAL (agree to Schedule V, line 22, col.8)	$ 514,533

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	$ 0
Advertising: Employee Recruitment	36,890
Health Care Worker Background Check	3,729
(Indicate # of checks performed 197)	
Patient Background Checks 311	3,110
Dues & Subscriptions	5,321
Association Dues	6,647
Advertising	22,059
Other Licenses and Permits	631
Less: Non-Allowable Association Dues	(1,894)
Less: Public Relations Expense	( )
Non-allowable advertising	(22,059)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,434

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,406
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)	$ 6,406

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland of Paxton # 0049494 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 $3198 & AHCA $1555**

(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. $ **29,626** 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. $ **160,217**
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. $ **838**

(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