FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0002923

Facility Name: Heartland Manor Nursing Center

Address: 410 N.W. Third Street (Number) Casey (City) 62420 (Zip Code)

County: Clark

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/17 to 6/30/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	81	Skilled (SNF)	81	29,565	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	81	TOTALS	81	29,565	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	6,973	8,951	2,695	18,619	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,973	8,951	2,695	18,619	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.98%

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 35 and days of care provided 2,695

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

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	255,669	24,133	6,343	286,145		286,145	-	286,145			1
2	Food Purchase		163,769		163,769	(8,432)	155,337	(21,305)	134,032			2
3	Housekeeping	89,538	16,560	-	106,098		106,098	-	106,098			3
4	Laundry	46,737	11,064	-	57,801		57,801	-	57,801			4
5	Heat and Other Utilities			111,852	111,852		111,852	-	111,852			5
6	Maintenance	57,561	9,836	34,995	102,392	(21,105)	81,287	-	81,287			6
7	Other (specify):* Trash/Waste Disposal	-	-	3,916	3,916		3,916	-	3,916			7
8	**TOTAL General Services**	449,505	225,362	157,106	831,973	(29,537)	802,436	(21,305)	781,131			8
	B. Health Care and Programs											
9	Medical Director	-	-	7,600	7,600		7,600	-	7,600			9
10	Nursing and Medical Records	1,133,389	72,072	10,022	1,215,483	21,105	1,236,588	-	1,236,588			10
10a	Therapy	-	-	-				-				10a
11	Activities	49,071	2,432	2,050	53,553		53,553	-	53,553			11
12	Social Services	37,667	-	2,050	39,717		39,717	-	39,717			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	1,220,127	74,504	21,722	1,316,353	21,105	1,337,458		1,337,458			16
	C. General Administration											
17	Administrative	61,379	-	-	61,379		61,379	-	61,379			17
18	Directors Fees			-				-				18
19	Professional Services			124,681	124,681	1,155	125,836	(2,220)	123,616			19
20	Dues, Fees, Subscriptions & Promotions			33,200	33,200	(6,565)	26,635	(1,809)	24,826			20
21	Clerical & General Office Expenses	115,930	10,462	30,888	157,280	(1,155)	156,125	(1,057)	155,068			21
22	Employee Benefits & Payroll Taxes			363,073	363,073	8,432	371,505	-	371,505			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			6,485	6,485		6,485	-	6,485			24
25	Other Admin. Staff Transportation		-	11,189	11,189		11,189	-	11,189			25
26	Insurance-Prop.Liab.Malpractice			46,787	46,787		46,787	-	46,787			26
27	Other (specify):*	-	-	-				-				27
28	**TOTAL General Administration**	177,309	10,462	616,303	804,074	1,867	805,941	(5,086)	800,855			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,846,941	310,328	795,131	2,952,400	(6,565)	2,945,835	(26,391)	2,919,444			29

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

Facility Name & ID Number Heartland Manor Nursing Center #0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			74,184	74,184		74,184	(22,964)	51,220			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			50,422	50,422		50,422	(8,975)	41,447			32
33	Real Estate Taxes			2,148	2,148		2,148	(2,148)				33
34	Rent-Facility & Grounds			-				-				34
35	Rent-Equipment & Vehicles			15,508	15,508		15,508	-	15,508			35
36	Other (specify):*			-				-				36
37	TOTAL Ownership			142,262	142,262		142,262	(34,087)	108,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	78,222	470,145	548,367		548,367	-	548,367			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			141,009	141,009		141,009	-	141,009			42
43	Other (specify):* Non-Allowable Cos	-	-	30,338	30,338	6,565	36,903	(36,903)				43
44	TOTAL Special Cost Centers		78,222	641,492	719,714	6,565	726,279	(36,903)	689,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,846,941	388,550	1,578,885	3,814,376		3,814,376	(97,381)	3,716,995			45

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

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	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,418)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,964)	30		9
10	Interest and Other Investment Income	(8,975)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,565)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,220)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,849)	43		24
25	Fund Raising, Advertising and Promotional	(5,401)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(35,989)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,381)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	-		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,381)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

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

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 7/01/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Ancillary Expense	$ (9,670)	43	1
2	Non Care Real Estate Taxes	(2,148)	33	2
3	Revenue Offset to Food	(21,305)	2	3
4	Nonallowable PAC Dues	(1,704)	20	4
5	Revenue Offset to Misc Exp	(1,057)	21	5
6	Chamber & Rotary Dues	(105)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(35,989)		49

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Preferred Bank		X	Technology	1266.93	12/19/14	$ 66,200	$ 21,840	12/19/19	0.055	$ 1,631	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Preferred Bank		X	Line of Credit	None	10/28/2016	1,000,000	825,000	4/28/2019	0.055	42,359	6
7												7
8	Various		X	Finance Charges							6,432	8
9	TOTAL Facility Related				$1,266.93		$ 1,066,200	$ 846,840			$ 50,422	9
	B. Non-Facility Related*											
10												10
11								Finance Charges			(6,432)	11
12								Interest Income Offset			(2,543)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,975)	14
15	TOTALS (line 9+line14)						$ 1,066,200	$ 846,840			$ 41,447	15

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

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

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	Alloc Fr. Mgmt Co.	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	N/A	8
	2014		9
	2015		10
	2016		11
	2017		12

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

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT Penny Chrysler, Administrator

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes on non-care assets; all		$	$
2.	costs are adjusted out of cost repor		$	$
3.			$	$
4.	03-11-19-08-203-049	Lot 2 Sturdevant & Goble Addtn	$ 2,132.64	$
5.	09-36-700-004	SW NE L: RRUSK2&3	$ 15.42	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,148.06	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,472	1964	$ 24,000	1
2					2
3	TOTALS	152,472		$ 24,000	3

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1964	1964	$ 385,838	$ -	25	$ -	$	$ 385,838	4
5			1966	1966	8,491		25			8491	5
6			1970	1970	3,400		25			3400	6
7			1972	1972	11,798		25			11798	7
8	21		1996	1996	828,949	24,353	40	20,724	(3,629)	455929	8
	Improvement Type**										
9	Building improvements			1973	7,123		10			7,123	9
10	Building improvements (less disposition of $1,076 in '07-'08)			1974	27,871		14-30			27,871	10
11	Building improvements (less disposition of $1,773 in 2005-06)			1975	5,291	-	10-30			5,291	11
12	Building improvements			1976	1,607	-	10-30			1,607	12
13	Building improvements			1977	1,808	-	7			1,808	13
14	Building improvements (less disposition of $4,880 in 2006-07)			1978	1,281	-	5-15			1,281	14
15	Building improvements			1979	949	-	10			949	15
16	Building improvements			1980	5,829	-	7			5,829	16
17	Building improvements			1981	1,376	-	7			1,376	17
18	Building improvements			1982	11,926	-	3-30			11,926	18
19	Building improvements			1983	6,263	-	5			6,263	19
20	Building improvements (less disposition of $1,974 in 2004-05)			1984	16,740	-	5-15			16,740	20
21	Building improvements (less disposition of $480 in 2005-06)			1985	5,320	-	5-15			5,320	21
22	Building improvements (less disposition of $28,007 in 2005-06)			1986	17,785	-	10-20			17,785	22
23	Building improvements (less disposition of $157 in 2006-07)			1987	27,530	-	5-15			27,530	23
24	Building improvements			1988	4,282		12-15			4,282	24
25	Building improvements (less disposition of $610 in '07-'08)			1989	2,259	-	15			2,259	25
26						-					26
27	Building improvements (less disposition of $2,795 in 2002-03)			1991	631	-	10			631	27
28	Heating/air system			1992	80,277		20			80,277	28
29	Building improvements			1992	3,084		10			3,084	29
30	Building improvements			1992	2,168		10			2,168	30
31											31
32	Building improvements			1992	647		10			647	32
33	Building improvements			1992	4,263		15			4,263	33
34	Ceiling/floor			1992	49,923		20			49,923	34
35	Sprinkler system			1992	60,121		20			60,121	35
36	Storage shelving			1993	4,090	-	10	-		4,090	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage shelving	1993	$ 1,003	$	10	$	$	$ 1,003	37
38	Resident security system	1993	3,909	-	20			3,909	38
39	Cabinets	1993	42,611		15-20			42,611	39
40	Heating/air/tubs	1993	29,226	-	20			29,226	40
41	Fire alarm system	1993	12,350	-	20			12,350	41
42	Plumbing and water system	1993	8,684	-	20			8,684	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493	-	20			10,493	44
45	Building improvements	1995	22,859	-	10-20			22,859	45
46				-					46
47	Architect fees	1996	74,806	1,870	40	1,870		39,758	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		16,166	48
49	Sprinklers	1996	9,774	244	40	244		5,124	49
50	Painting	1996	4,052	101	40	101		1,984	50
51	General contractor fees	1996	7,841	196	40	196		4,116	51
52	Electrical	1996	18,390	460	40	460		9,447	52
53	Chapel work - New Hutton	1996	12,572		40			12,572	53
54	Cubicle curtain tracking	1996	742	-	20			742	54
55	Room signs	1996	3,331	-	20			3,331	55
56	Emergency lighting Jones wing	1996	142	-	20			142	56
57	Bath systems Jones wing	1996	8,610	-	20			8,610	57
58	Sprinklers Jones wing	1996	340	-	10			340	58
59	Security locks Jones wing	1996	1,049	-	20			1,049	59
60				-					60
61	Call lights Jones wing	1996	1,881	-	11			1,881	61
62	Air filtration Jones wing	1996	2,081	-	20			2,081	62
63	Wiring-computers & phone	1996	2,970	-	5			2,970	63
64	Hallway support bars	1996	750	-	10			750	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		2,475	65
66	Plumbing	1996	4,640	32	20		(32)	4,640	66
67	Electrical work (less disposition of $1,500 in 2005-06)	1996	3,162	-	20			3,162	67
68	Flooring	1996	2,400		20			2,400	68
69	Courtyard	1996	2,766		20			2,766	69
70	TOTAL (lines 4 thru 69)		$ 1,919,114	$ 28,131		$ 24,470	$ (3,661)	$ 1,475,309	70

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,919,114	$ 28,131		$ 24,470	$ (3,661)	$ 1,475,309	1
2	Concrete work entrance	1996	1,470	6	20		(6)	1,470	2
3	Building appraisal	1997	2,578	64	40	64		640	3
4	Chapel HVAC	1997	2,324	54	20		(54)	2,324	4
5	Stained glass window	1997	2,052		20			2,052	5
6	Steel door	1997	422		20			422	6
7									7
8									8
9	Hand rails	1997	5,252		20			5,252	9
10									10
11	Walk in cooler	1997	11,524		20	50	50	11,524	11
12	Fire system work	1997	513	2	20	1	(1)	513	12
13	Key pad - security system	1997	360	2	20	3	1	360	13
14									14
15	Tile flooring - Lobby	1997	900	8	20	11	3	900	15
16									16
17	Bed light installation	1998	1,826	53	20	64	11	1,826	17
18	Hand rails	1998	1,413	53	20	50	(3)	1,413	18
19	Sprinklers	1998	708	26	20	30	4	708	19
20	Generator bypass switch	1998	1,567	78	20	68	(10)	1,567	20
21									21
22	Lighting - kitchen	1998	985	-	20	-		546	22
23	Paging system	1998	516	26	20	26		516	23
24	Room divider remodeling	1998	391	20	20	17	(3)	391	24
25	Bathroom lighting	1998	1,090	27	20	55	28	1,085	25
26	South wing remodeling	1998	165	8	20	8		88	26
27	Roof over generator room	1998	568	28	20	28		559	27
28	Bathrooms	1998	7,394	370	20	370		7,305	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		6,080	29
30	Fire Alarm System	1999	1,317	66	20	66		1,269	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		1,586	31
32		1999	1,760	44	20	88	44	1,687	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 1,974,070	$ 29,459		$ 25,862	$ (3,597)	$ 1,527,392	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,974,070	$ 29,459		$ 25,862	$ (3,597)	$ 1,527,392	1
2	Generator panel	2000	2,023	-	10	-		2,023	2
3	Gazebo	2000	2,733		10			2,733	3
4	Anti-scald valves (2)	2001	655		10			655	4
5	Shower floor replacement	2001	500	25	20	25		438	5
6	Dining room lights	2001	6,013	150	20	301	151	5,265	6
7						-			7
8	Toilet stools & seats	2001	1,414	-	10	-		1,414	8
9	Parking lot asphalt reseal	2001	5,032	252	20	251	(1)	4,208	9
10	Ceramic wall tile	2001	365	18	20	18		303	10
11	Washer & nurse call	2001	485	-	10	-		485	11
12	Bath fans	2001	150	-	10	-		150	12
13	Extend legs on links	2001	607	-	10	-		607	13
14	Wallpaper front lobby	2001	150	-	10	-		150	14
15	Remodel North & South showers	2002	2,332	117	20	116	(1)	1,889	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912		10			912	16
17	Water heater	2002	4,165	104	20	208	104	3,347	17
18				-		-			18
19	Compressor - freezer	2002	810	-	10	-		810	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		579	20
21	Carpet	2003	2,887	144	20	144		2,270	21
22	Bypass switch for generator	2003	2,166	108	20	108		1,639	22
23	Sign	2003	850	-	10	-		850	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		2,757	25
26	Water Heater	2004	6,548	327	20	327		4,771	26
27	Wireless Monitoring System	2004	4,263		10			4,263	27
28	Water heater	2004	3,475	174	20	174		2,507	28
29	Lights, smoke detectors, other	2004	2,562		10			2,562	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		$ 2,033,608	$ 31,119		$ 27,775	$ (3,344)	$ 1,574,979	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,033,608	$ 31,119		$ 27,775	$ (3,344)	$ 1,574,979	1
2	Security fence (less disposition of $2,352 in 2005-06)	2005		-		-			2
3	Windows - North wing	2005	5,320	266	20	266		3,702	3
4	Roof air conditioner - dietary	2005	3,997	266	20	266		3,704	4
5	Windows - South Wing	2005	5,499	275	15	275		3,781	5
6	Windows - H Wing	2005	4,132	207	20	207		2,828	6
7	Handrails	2005	1,375	92	20	92		1,248	7
8	2 ton compressor	2005	558	37	15	37		557	8
9									9
10	Replace tile in driveway	2005	13,100	655	20	655		8,351	10
11	Generator	2005	20,000		10			20,000	11
12									12
13	Roof	2006	10,657	182	39	273	91	3,276	13
14	Nurses Station - Countertop	2007	2,736	182	15	182		1,847	14
15						-			15
16	Roof Repair	2008	4,587	164	27.5	167	3	1,670	16
17									17
18	Canopy Sprinkler System	2008	9,685	646	15	646		6,352	18
19	Jones Wing Door Alarms	2008	3,706	124	15	247	123	2,367	19
20	Hutton Wing New Doors	2009	5,100	340	15	340		3,230	20
21						-			21
22	Light Fixtures-All Areas	2010	19,737	1,038	20	987	(51)	7,978	22
23									23
24	Water Heater	2011	4,153	208	20	208		1,560	24
25	Door	2011	2,955	148	15	197	49	1,478	25
26									26
27	Backup Generator Meter	2011	3,467	173	20	173		1,125	27
28						-			28
29	Kitchen A/C Unit	2012	7,084	472	15	472		3,068	29
30				-		-			30
31				-		-			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,161,456	$ 36,594		$ 33,465	$ (3,129)	$ 1,653,101	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,161,456	$ 36,594		$ 33,465	$ (3,129)	$ 1,653,101	1
2				-		-			2
3	Water Heater	2013	4,385	219	20	219		1,205	3
4	Generator Transfer Switch	2013	2,965	148	20	148		814	4
5	Condensing Unit for Walkway	2013	4,768	318	15	318		1,749	5
6						-			6
7	Landscaping & fountain in front of facility	2014	7,280	364	20	364		1,638	7
8	Installation of digital phone system	2014	6,262	1,252	5	1,252		5,635	8
9	Wiring and labor for installation of EHR capability	2014	7,241	362	20	362		1,629	9
10	Replace condenser on A/C - Dining Room Area	2014	3,323	147	20	166	19	748	10
11	Front office remodel: carpet, paint & tiling	2014	3,157	23	20		(23)	552	11
12						-			12
13	Water Softener - Mechanical Room	2014	2,642	132	10	132	0	528	13
14	Water Heater Southwest Shower	2014	4,385	219	10	219	0	877	14
15				-		-			15
16	Roof	2017	121,884	3,125	39	3,125		4,688	16
17									17
18	Pavilion - Courtyard	2017	3,143	157	20	157		157	18
19									19
20	To reconcile to financial statements			19,832			(19,832)		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)		$ 2,332,891	$ 62,892		$ 39,928	$ (22,964)	$ 1,673,322	34

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

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	$ 89,589	$ 9,564	$ 9,564	$ -	3-20 years	$ 81,020	71
72	Current Year Purchases	11,250	328	328	-	10 years	328	72
73	Fully Depreciated Assets	473,610			-	3-15 years	473,610	73
74					-			74
75	TOTALS	$ 574,449	$ 9,892	$ 9,892	$		$ 554,958	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1994 Ford Van	1995	$ 41,610	$ -	$ -	$ -	5	$ 41,610	76
77	Resident Care	2005 Chevy Venture Van	2014	7,000	1,400	1,400	-	5	6,300	77
78							-			78
79							-			79
80	TOTALS			$ 48,610	$ 1,400	$ 1,400	$		$ 47,910	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,979,950	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 74,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 51,220	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,964)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,276,190	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	See Schedule 13A Attached	$ 101,600	$ 1,212	$ 81,400	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 101,600	$ 1,212	$ 81,400	91

G. Construction-in-Progress

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

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

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

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/18**

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Aklinski Building	1994	40,045	1,027		-		23,360
	Aklinski concrete work	1994	3,900			-		3,900
	Land		5,000			-		5,000
	Architect fees for Assisted Living	2005	2,915			-		2,915
	410 NW 3rd Street - Land		46,040			-		46,040
	AC Unit/Furnace	2018	3,700	185		-		185
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			**101,600**	**1,212**	**-**	**-**		**81,400**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 15,508 Description: Please see SCH 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Dishwasher	910
Washer/Dryer	1,050
Oxygen Equipment	9,383
Wound vac	4,165
Total - Line 16	**15,508**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 39, C3	hrs	$	2,429	$ 155,782	$	2,429	$ 155,782	1
2	Licensed Speech and Language Development Therapist	Ln 39, C3	hrs		627	32,385		627	32,385	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 39, C3	hrs		4,495	281,978		4,495	281,978	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, C2	# of prescrpts				71,301		71,301	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Ther Supplies	Ln 39, C2					6,921		6,921	12
13	Other (specify):									13
14	TOTAL			$	7,551	$ 470,145	$ 78,222	7,551	$ 548,367	14

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/18 (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	$ 44,691	$ 44,691	1
2	Cash-Patient Deposits	8,152	8,152	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 732,267)	857,660	857,660	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,756	34,756	6
7	Other Prepaid Expenses	38,908	38,908	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 984,167	$ 984,167	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,040	24,000	13
14	Buildings, at Historical Cost	2,322,406	2,332,891	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	634,365	623,059	16
17	Accumulated Depreciation (book methods)	(2,265,242)	(2,276,190)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spc Security Deposits	334	334	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 766,903	$ 704,094	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,751,070	$ 1,688,261	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 393,484	$ 393,484	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,252	8,252	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,753	140,753	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,357	69,357	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	31,040	31,040	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 642,886	$ 642,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	846,840	846,840	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)**	$ 846,840	$ 846,840	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,489,726	$ 1,489,726	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 261,344	$ 198,535	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,751,070	$ 1,688,261	48

***(See instructions.)**

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/18**

Schedule 17A

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

	Description	Operating	After Consolidation
110218	Balance Transfer Clearing Account	76	76
110219	Patient Refund Clearing Account	30,659	30,659
210109	401k Payables	200	200
210112	Employee Deductions - Credit Union	15	15
210114	Unearned Room Revenue	90	90
	Total - Line 36	**31,040**	**31,040**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 406,911	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(31,709)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 375,202	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,858)	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)**	$ (113,858)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 261,344	24 *

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,586,198	1
2	Discounts and Allowances for all Levels	118,839	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,705,037	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	857,478	6
7	Oxygen	776	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 858,254	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	21,305	14
15	Telephone, Television and Radio	2,352	15
16	Rental of Facility Space	6,000	16
17	Sale of Drugs	76,523	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,325	19
20	Radiology and X-Ray	448	20
21	Other Medical Services	20,813	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 132,766	23
	D. Non-Operating Revenue		
24	Contributions	114	24
25	Interest and Other Investment Income***	2,543	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,657	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule 19A	1,804	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,804	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,700,518	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	831,973	31
32	Health Care	1,316,353	32
33	General Administration	804,074	33
	B. Capital Expense		
34	Ownership	142,262	34
	C. Ancillary Expense		
35	Special Cost Centers	578,705	35
36	Provider Participation Fee	141,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,814,376	40
41	**Income before Income Taxes (line 30 minus line 40)****	(113,858)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (113,858)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 840,949	44
45	Private Pay - Net Inpatient Revenue	1,180,136	45
46	Medicare - Net Inpatient Revenue	683,952	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,705,037	49

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

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

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

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

^ Entity is a cash basis taxpayer

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/18**

Schedule 19A

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

	Description	Amount
568000	Oil Income	747
569000	Miscellaneous Income	1,057
	Total - Line 28	**1,804**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,301	2,558	$ 66,952	$ 26.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,149	10,942	225,310	20.59	3
4	Licensed Practical Nurses	11,190	11,866	260,298	21.94	4
5	CNAs & Orderlies	40,712	42,887	509,077	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,022	2,209	24,360	11.03	9
10	Activity Assistants	1,747	1,847	24,711	13.38	10
11	Social Service Workers	3,205	3,588	37,667	10.50	11
12	Dietician					12
13	Food Service Supervisor	2,315	2,477	41,335	16.69	13
14	Head Cook	7,381	8,897	89,573	10.07	14
15	Cook Helpers/Assistants	12,692	13,576	124,761	9.19	15
16	Dishwashers					16
17	Maintenance Workers	4,245	4,682	57,561	12.29	17
18	Housekeepers	7,741	8,373	89,538	10.69	18
19	Laundry	3,926	3,844	46,737	12.16	19
20	Administrator	2,032	2,080	61,379	29.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,298	8,073	115,930	14.36	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	2,057	2,285	26,342	11.53	31
32	Other Health C: MDS Coordinator	2,541	3,016	45,410	15.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,554	133,200	$ 1,846,941 *	$ 13.87	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 6,343	L1, C3	35
36	Medical Director	12	7,600	L9, C3	36
37	Medical Records Consultant	12	1,560	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	2,050	L11, C3	44
45	Social Service Consultant	24	2,050	L12, C3	45
46	Other(specify) Utilization Review	Monthly	1,688	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	264	$ 24,491		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	117	3,574	L10, C3	52
53	TOTAL (lines 50 - 52)	117	$ 3,574		53

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Penny Chrysler	Administrator	0	$ 61,379
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,379

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Quorum Consulting Group	401(k) Administrator	$ 2,286
RSM US LLP	Accounting	45,156
Duane Morris	Legal	77,239
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 124,681

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,282
Unemployment Compensation Insurance	
FICA Taxes	153,949
Employee Health Insurance	144,274
Employee Meals	8,432
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	
Labs & Physicals	4,568
Employee Life Insurance	
TOTAL (agree to Schedule V, line 22, col.8)	$ 371,505

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	36
Health Care Worker Background Check	
(Indicate # of checks performed 15)	450
Patient Background Checks 81	686
Miscellaneous Licenses & Fees	8,994
Miscellaneous Dues & Subscriptions	15,698
IL Healthcare Assoc. Dues	5,346
Less: Penalty	(6,565)
Less: Rotary Dues	(105)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,704)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,826

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,946
Seminar Expense	2,539
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,485

**See instructions.

Facility Name: **Heartland Manor Nursing Center**
IDPH License ID Number: **0002923**
Fiscal Year End: **6/30/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Quorum Consulting Group	401(k) Administrator	2,286
RSM US LLP	Accounting	45,156
Duane Morris	Legal	77,239

Total (agree to Schedule V, line 19, column 3)		124,681
Add:	Reclass Unemployment Fees	1,155
Less:	Non-Allowable Legal Fees	(2,220)
Total (agree to Schedule V, line 19, column 8)		123,616

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 7/01/17 Ending: 6/30/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $3,642**

(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? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,189** Line **L10, C2**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **141,009**
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. $ **8,432** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **21,305**

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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